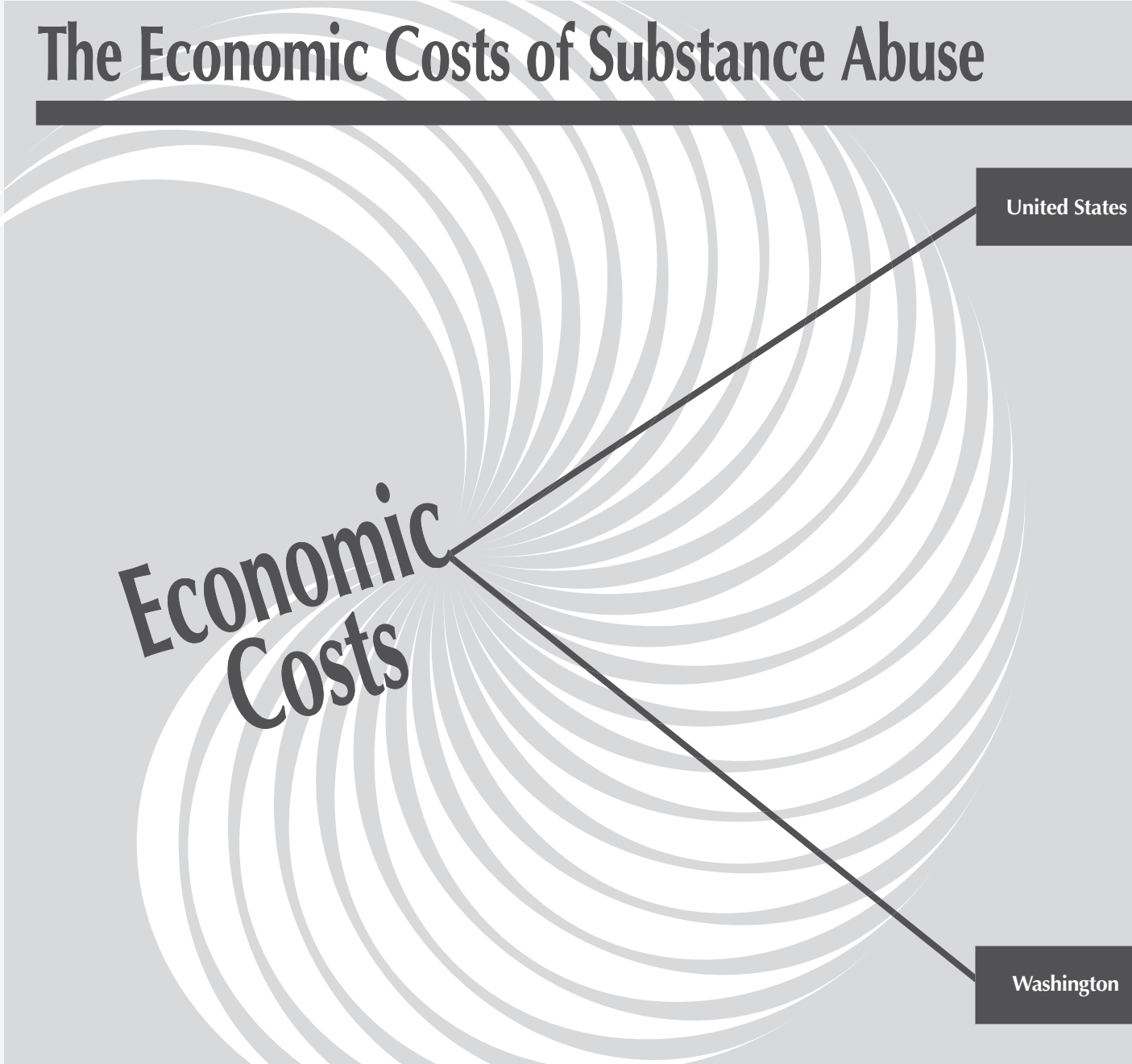

The Economic Costs of Substance Abuse

**Economic
Costs**

United States

Washington



The Economic Costs of Substance Abuse

**Economic
Costs**

United States

Washington



The Economic Costs of Substance Abuse in the United States

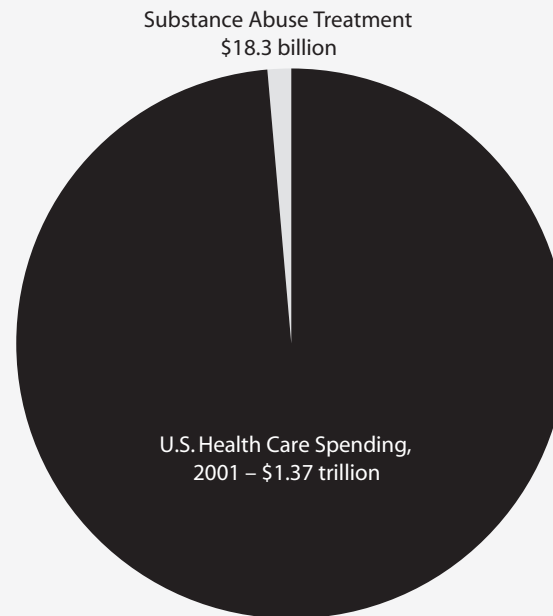
Two studies – one sponsored by the National Institute on Alcohol Abuse and Alcoholism, the other by the White House Office of Drug Control Policy – estimate the total economic costs of alcohol and drug abuse in the United States at \$328 billion in 1998.¹

Among the study's key findings were:

- Alcohol abuse accounted for 56.3% of the total economic costs; 43.7% were attributable to drug abuse.
- More than 55,000 deaths were attributable to substance abuse, 65% of them to alcohol.
- Total medical costs related to alcohol and drug abuse (\$31.8 billion) were approximately two-and-a-half times that spent on treatment (\$12.9 billion).
- Of the \$143.4 billion in economic costs related to drug abuse, 69% were in lost productivity, 9% in health care costs, and 22% in other costs, including the costs of crime, police, and the criminal justice system.
- Health costs related to alcohol abuse (\$18.9 billion) were 68% higher than for drug-related health costs (\$12.9 billion).
- Only 3.9% of total economic costs were for alcohol/drug treatment.

¹ Harwood, H. *Updating Estimates of the Economic Costs of Alcohol Abuse in the United States: Estimates, Update, and Data*. Rockville, MD: U.S. Department of Health and Human Services, U.S. Public Health Service, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, 2000; Office of National Drug Control Policy. *The Economic Costs of Drug Abuse in the United States, 1992-1998*. Washington, DC: Executive Office of the President, 2001.

Nationally, Only 1.3% of the Almost \$1.4 Trillion Spent on Health Care in the United States Goes for Substance Abuse Treatment.

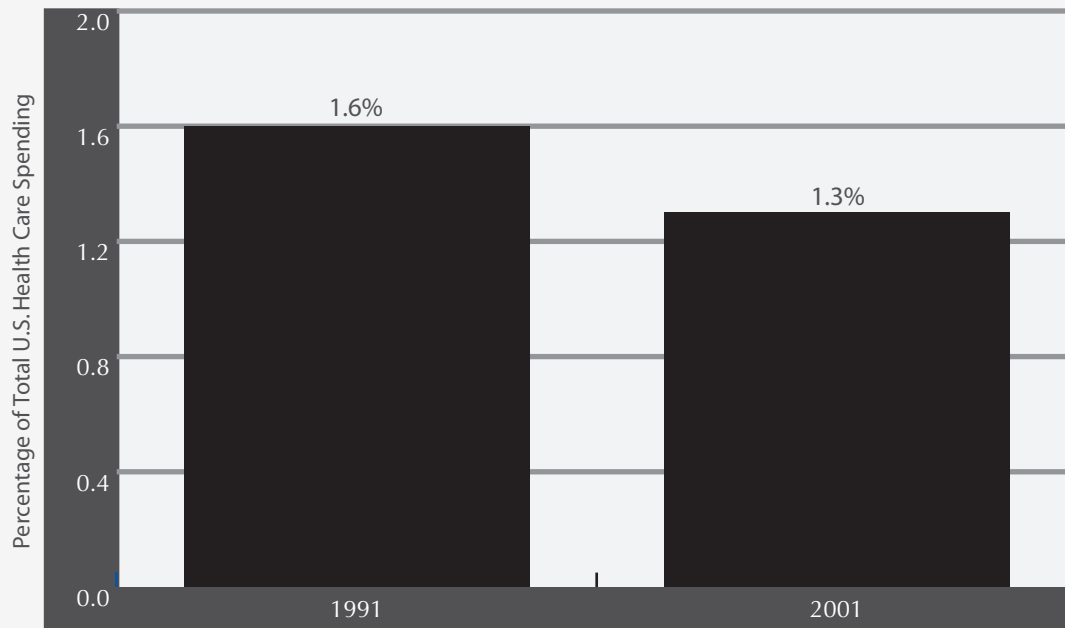


Source: Mark, T. et al., "U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001." *Health Affairs* – Web Exclusive, 2005.

A 2005 study published in the journal *Health Affairs* found that, of the \$1.37 trillion spend on health care in the United States in 2001, only \$18.3 billion (1.3%) went for substance abuse treatment.

Despite scientifically demonstrated cost offsets in decreased mortality, lower crime and criminal justice costs, higher worker productivity, less reliance on public assistance and other social services, fewer medical and psychiatric hospitalizations and emergency room visits, and lower health care costs, chemical dependency treatment remains extremely underfunded at both the state and federal level.

**As a Percentage of Total U.S. Spending
on Health Care, Spending on
Substance Abuse Treatment Declined
14.5% Between 1991 and 2001.**



Source: Mark, T. et al., "U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001. *Health Affairs* – Web Exclusive, 2005.

A 2005 study published in the journal *Health Affairs* found that, as a percentage of the of the total spent on health care in the United States, spending on substance abuse treatment fell from 1.6% in 1991 to 1.3% in 2001, representing a 14.5% decline.

Substance abuse treatment has been scientifically proven to produce cost offsets in decreased mortality, lower crime and criminal justice costs, higher worker productivity, less reliance on public assistance and other social services, fewer medical and psychiatric hospitalizations and emergency room visits, and lower health care costs. Despite this, chemical dependency treatment remains extremely underfunded at both the state and federal level. Of the \$4,851 spent on health care in the U.S. in 2001, only \$65 went for substance abuse treatment.¹

¹ Mark, T. et al. "U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001. *Health Affairs* – Web Exclusive, March 29, 2005.

The Economic Costs of Substance Abuse

**Economic
Costs**

United States

Washington



The Economic Costs of Substance Abuse in the Washington State

A study sponsored by the Division of Alcohol and Substance Abuse estimated the total economic costs of alcohol and drug abuse in Washington State at \$2.54 billion in 1996.¹ This represents approximately \$531 for every non-institutionalized resident in the state.

Among the study's key findings were:

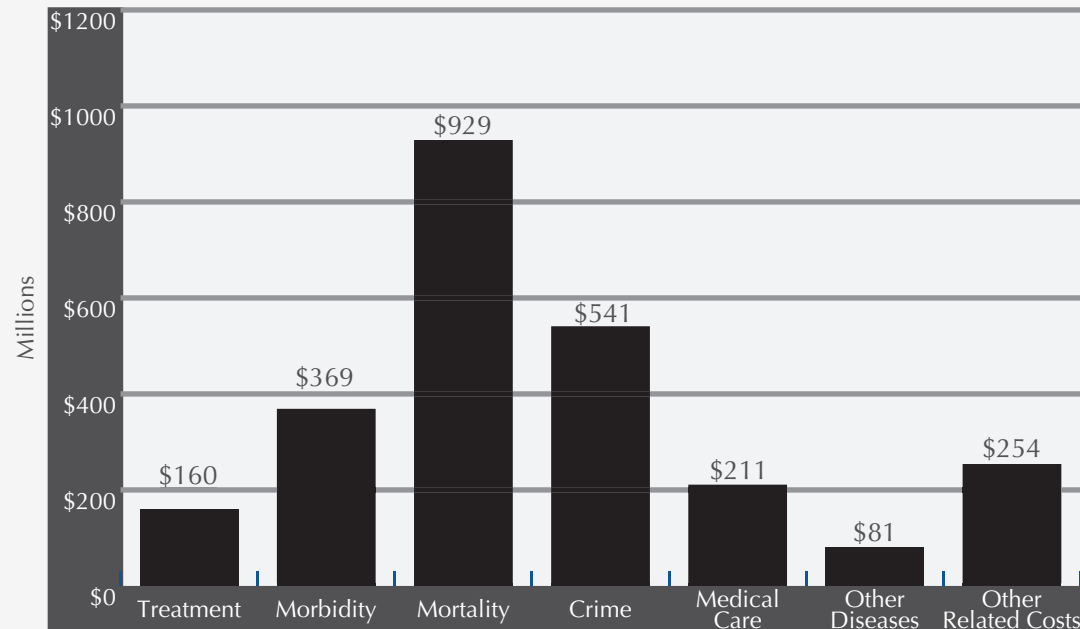
- *59% of the economic costs were attributable to the use of alcohol; 41% to the use of drugs.*
- *There were 2,824 deaths in 1996 caused by or related to alcohol or drug abuse, representing approximately 70,000 potential life-years lost.*
- *Of the 2,824 deaths, 2,318 were alcohol-related, and 506 were drug-related.*
- *Leading causes of substance abuse-related deaths were motor vehicle accidents (353 deaths), alcohol cirrhosis (291 deaths), and suicide (223 deaths).*
- *Of 217 arrests for homicide, 65 were alcohol-related, and 22 were drug-related.*
- *Of 6,003 arrests for felonious assault, 1,801 were alcohol-related, and 144 were drug-related.*
- *There were 16,000 hospital discharges classified as alcohol- or drug-related.*
- *Total estimated alcohol- and drug-related crime costs in 1996 rose to \$541 million from \$348 million in 1990, representing a 55% increase.*

¹ Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

Costs Related to Mortality, Crime, and Morbidity Represent the Largest Economic Costs of Drug and Alcohol Abuse.



Economic Costs of Drug and Alcohol Abuse in Washington, 1996



Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Washington State Division of Alcohol and Substance Abuse, 1999.

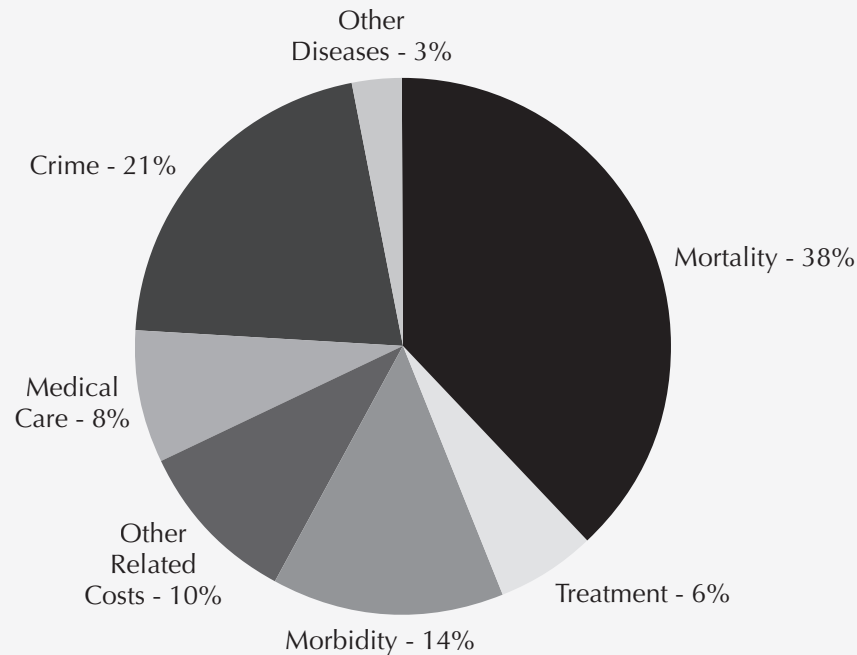
This graph indicates that mortality-, crime-, and morbidity-related costs represented the largest economic costs of substance abuse in 1996. The estimated cost per death measured in terms of lost income was \$329,000.¹ Adult and juvenile arrests for drug offenses in Washington State increased 287% from State Fiscal Years 1985 to 2002, while adult felony superior court filings for drug offenses increased by 406% in the same period.

¹ Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.



Treatment Represented Only 6% of the Total Economic Costs of Alcohol and Drug Abuse in 1996.

Distribution of Drug and Alcohol Costs



Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

This chart indicates that alcohol and drug treatment represents a very small fraction of the total economic costs of substance abuse in Washington State.¹ Yet, data — much of which is contained in this report — indicate that treatment can contribute significantly to lower morbidity and mortality, decreased crime, increased employment and higher worker productivity, reduced spread of infections diseases, and lower medical costs. Alcohol and drug treatment continue to be wise investments in the health and safety of communities, and the economic vitality of Washington State.

¹ Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 1996*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

Impacts of Substance Abuse on the Washington State Budget



A 2001 study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) estimated 1998 state government spending on the consequences of substance abuse in Washington State at \$1.5 billion. Only 4% of that total was spent on prevention and treatment.¹

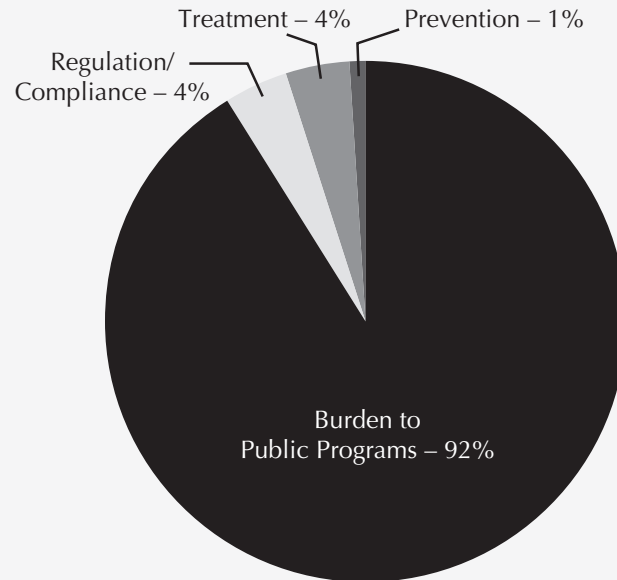
Other key findings of the study included:

- *Nationally, of a total of \$620 billion in state government spending, \$81.3 billion (13.1%) was used to deal with substance abuse and addiction.*
- *Of every such dollar spent by states, 96 cents went to “shoveling up the wreckage of substance abuse and addiction”; only four cents was used to prevent and treat it.*
- *Combined, states spent 113 times as much to deal with the devastation substance abuse and addiction wrought upon children as they did to prevent and treat it.*
- *Of the \$25 billion spent on dealing with the impacts of substance abuse on children, \$16.5 billion was borne by the public education system; another \$5.3 billion was spent on services for children who were victims of substance abuse and neglect; and almost \$3 billion was spent serving substance-involved youth in states’ juvenile justice systems.*
- *Each American paid \$277 per year in state taxes to deal with the burden of substance abuse and addiction within social programs, and only \$10 for prevention and treatment.*



Of the \$13.9 Billion in Washington State Government Spending in 1998, \$1.5 Billion (10.9%) was Spent on Services Related to Impacts of Substance Abuse.

***Distribution of State Spending
Related to Impacts of Substance Abuse***

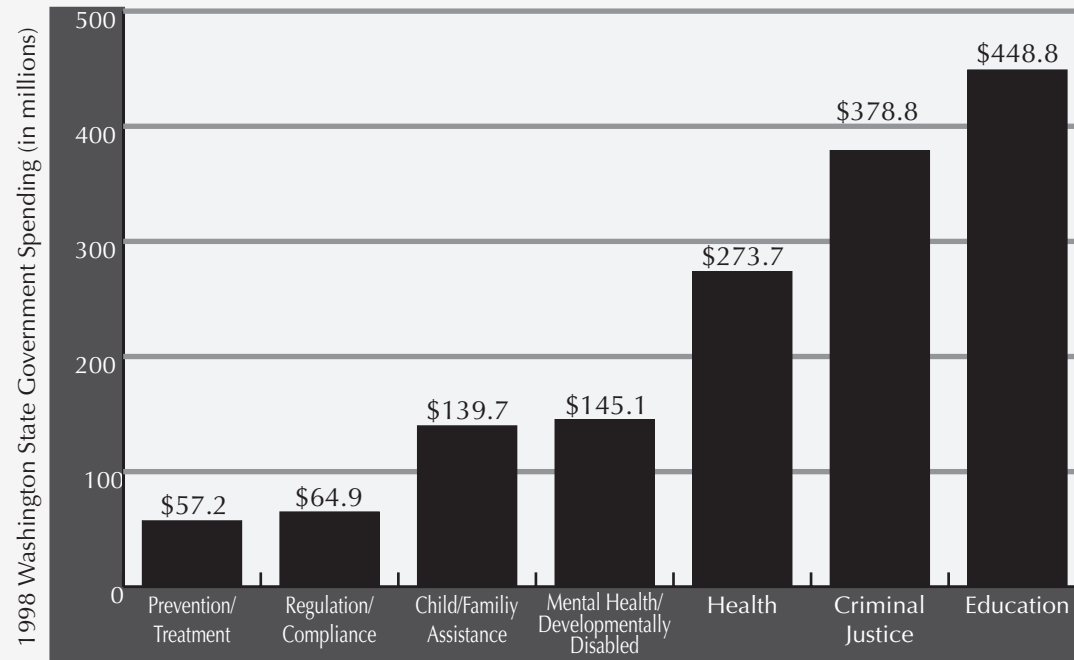


Source: Data from National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets*, 2001.

In 1998, the \$1.51 billion of Washington State government spending related to the impacts of substance abuse compares with \$2.65 billion spent on higher education, \$1.46 billion spent on Medicaid, and \$1.09 billion spent on transportation.¹

¹ National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up: The Impact of Substance Abuse on State Budgets*. New York, NY: 2001.

Substance Abuse Results in Significantly Higher State Government Spending on Education, Criminal Justice, and Health.



Source: Data from National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets*, 2001.

In 1998, 10% of Washington State government spending, or \$248 for every resident, was related to impacts of substance abuse. Only approximately \$10 of this amount went for prevention and treatment.¹

The Problem: Substance Abuse Prevalence & Trends

PREVALENCE

Adolescent
Substance
Use and Beliefs

Adult
Substance
Use

The Problem: Substance Abuse Prevalence & Trends

PREVALENCE

Adolescent
Substance Use
and Beliefs

Adult
Substance
Use



Washington's Healthy Youth Survey

In Washington State, multiple state agencies have been conducting surveys of youth health behavior since 1988. The surveys have been based on two different national surveys: Monitoring the Future supported by the National Institute on Drug Abuse; and the federal Centers for Disease Control and Prevention's Youth Risk Behavior Survey. In 1995, a Communities That Care survey, developed by the University of Washington, became an important component of the survey effort, integrating risk and protective factors. More recently, a Youth Tobacco Survey was incorporated.

To better coordinate these survey efforts, and to prevent the need for survey data from becoming an undue burden on schools, interested state agencies – Office of Superintendent of Public Instruction; Department of Social and Health Services' Division of Alcohol and Substance Abuse; Department of Health's Tobacco Control Program and Maternal and Child Health Program; Department of Community, Trade & Economic Development, Community Mobilization; and the Family Policy Council – resolved to cooperate on the administration of a single survey of youth behaviors every two years, to be administered in the fall.

The goals of this collaborative effort are:

- To describe youth health behavior, habits, risks, and outcomes; and
- To describe school, community, family, and peer/individual risk and protective factors.

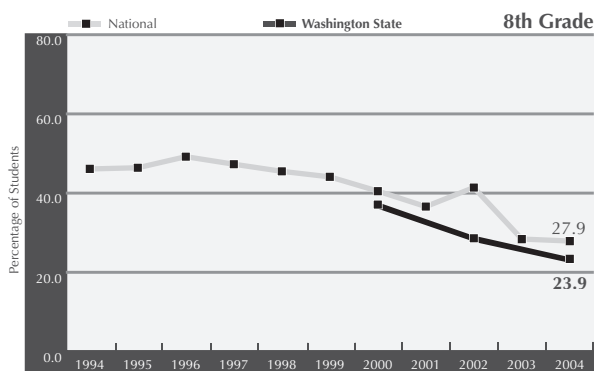
To achieve these goals, it was agreed that the survey must:

- Gather state-level data in a consistent manner (with predictable timing and using comparable measures over time); and
- Support local-level data collection and use for planning, assessment, and evaluation of programs to serve youth.

The data represented on the following pages are from the Healthy Youth Survey, which represents the result of these collaborative efforts. Complete data from the Healthy Youth Survey are available on-line at the Washington State Department of Health's website: www3.doh.wa.gov/HYS/default.htm.

The Prevention Standing Committee of the Governor's Council on Substance Abuse has set a series of state targets for prevention efforts. These targets are continually revised as progress is made in improving the effectiveness of prevention strategies.

The Percentage of Students, Both in Washington and Nationally, Who Have Ever Tried Smoking is Declining.*



Tobacco use is the leading cause of preventable illness and death in the United States.¹ A 1996 federal Centers for Disease Control and Prevention Study suggests that 33% of young smokers will eventually die as a result of tobacco use, if current use patterns continue.²

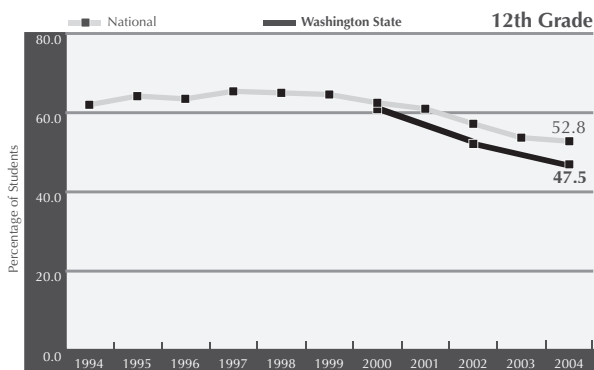
These graphs indicate that experimentation with tobacco is on the decline, both in Washington State and nationally. The state target is to raise the average age of adolescents' first use of tobacco products to 16.

¹ U.S. Surgeon General. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

² Centers for Disease Control and Prevention. "Projected Smoking-Related Deaths Among Youth – United States," *Morbidity and Mortality Weekly Report* 45, 1999.



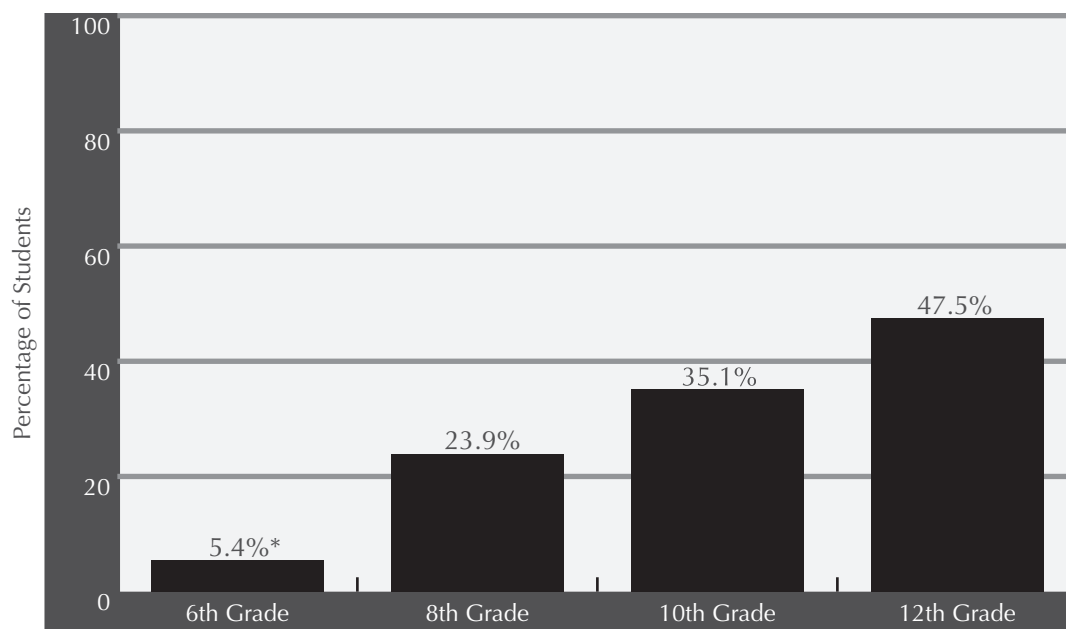
* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.



Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.



By 12th Grade, Almost Half of Washington Adolescents Have Tried Smoking.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

The percentage of Washington State students who have experimented with smoking is declining. Experimentation and use of smokeless tobacco is also on the decline.¹

Research indicates that increasing tobacco taxes on cigarettes, when combined with anti-smoking campaigns, is one of the most cost-effective short-term strategies to prevent tobacco initiation about youth.² A recent study found that 70% of U.S. youths ages 14-17 report they can purchase cigarettes within five blocks of their home.³ However, the Washington State Healthy Youth Survey found that only 19% of 10th grade youth reported they usually obtained tobacco by purchasing it themselves; 63% obtained it from others.⁴

*6th grade percentage is for students smoking a whole cigarette; 8th, 10th, and 12th grade data are for students trying smoking, “even just a puff”.

¹ Office of Superintendent of Public Instruction. *Washington State Healthy Youth Survey – 2004*. Olympia, WA: 2005.

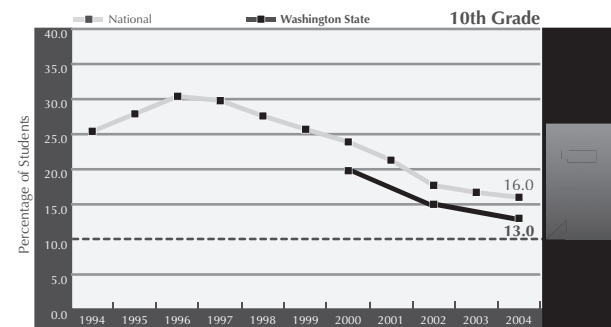
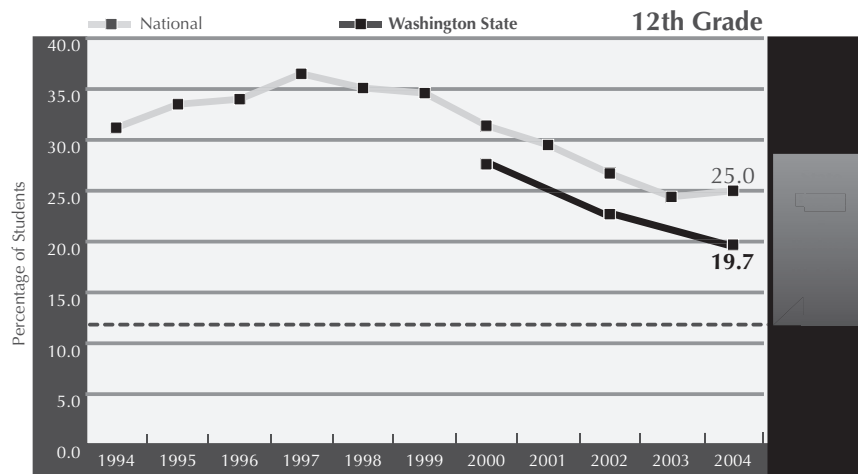
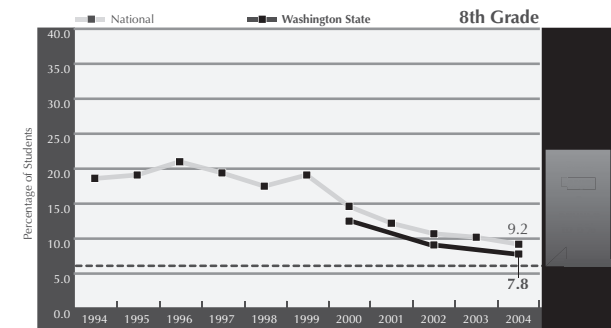
² U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 27-6. Washington, DC: 2000.

³ Institute for Adolescent Risk Communication. *Access to Risky Products and Perceptions of Risky Behavior and Popularity*. Philadelphia, PA: University of Pennsylvania, Annenberg Public Policy Center, 2002.

⁴ *Healthy Youth Survey*, op. cit.

In 2004, Washington State 8th, 10th, and 12th Graders were Less Likely to Have Smoked a Cigarette in the Past 30 Days than in Previous Years.*

Recent smoking by adolescents appears to be on the decline, both in Washington State and nationwide. Studies indicate that youth and young adult smokers are more price-responsive than other smokers, and that a 10% increase in price could reduce the number of teenagers who smoke by 7%.¹



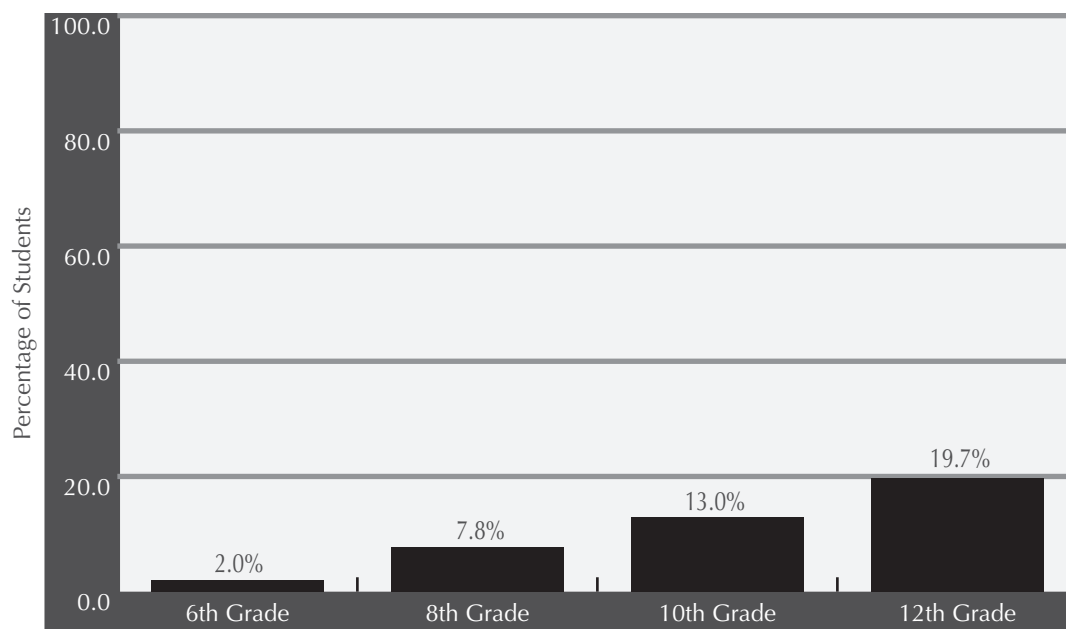
Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

¹ Schneider Institute for Health Policy, Brandeis University. *Substance Abuse – The Nation's Number One Health Problem: Key Indicators for Policy – Update February 2001*. Princeton, NJ: The Robert Wood Johnson Foundation, 2001.



Almost a Fifth of Washington High School Seniors Report Having Smoked a Cigarette in the Past 30 Days.



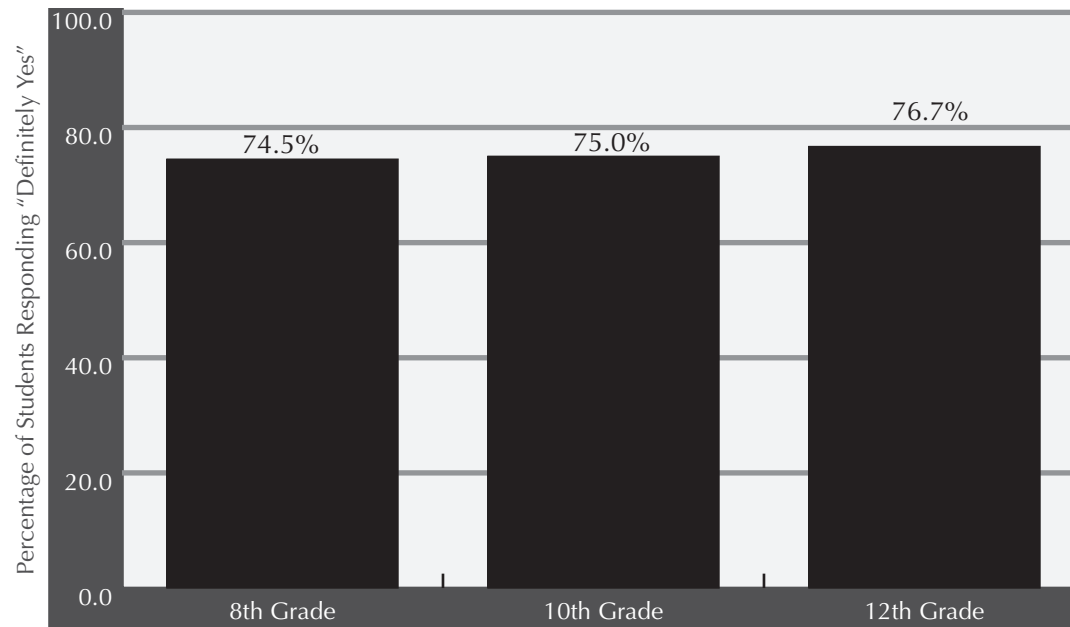
Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

Among young people, short-term health consequences of smoking include respiratory and non-respiratory effects, nicotine addiction, and the associated risk of other drug use. Long-term health consequences of youth smoking are reinforced by the fact that most young people who begin to smoke regularly in their youth continue to do so as adults.¹ A large majority of Washington State students who smoke report that they want to quit, and more than half have tried to stop during the previous year.²

¹ U.S. Surgeon General. *Tobacco Use Among Young People – A Report of the Surgeon General*. Washington, DC: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1994.

² Office of Superintendent of Public Instruction. *Washington State Healthy Youth Survey – 2004*. Olympia, WA: 2005.

In 2004, Most Washington State Students Believed that Young People Risk Harming Themselves by Smoking 1-5 Cigarettes Per Day.



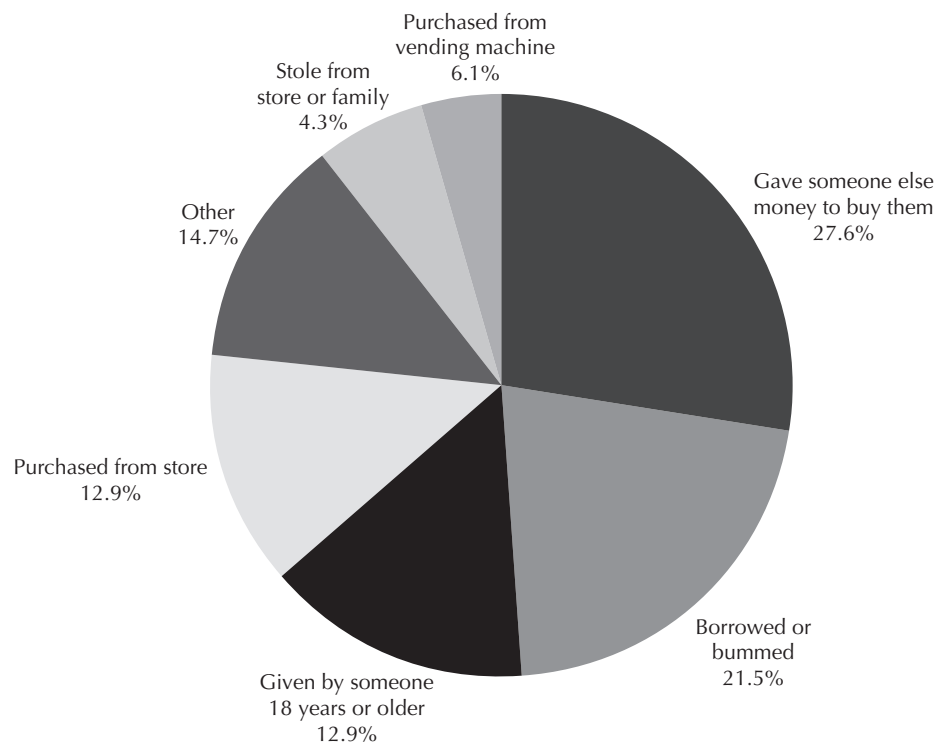
Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

Most Washington State students perceive a high degree of risk from smoking cigarettes. The percentage perceiving such risk rises as students get older, even as the rate of smoking among students increases. This suggests that new efforts need to be focused on helping current young smokers quit. Some 46% of Washington 10th graders, and 42% of 12th graders who smoke report they would like to quit immediately, but fewer than a fifth of these smokers have had access to a program to help them quit.¹ Perception of risk of harm from smoking has been rising in recent years, especially among students in the younger grades, suggesting that anti-smoking efforts have been having an impact.

¹ Office of the Superintendent of Public Instruction. *Washington State Healthy Youth Survey – 2004*. Olympia, WA: 2005.



Most 10th Grade Smokers in Washington State Obtain Cigarettes from Others.

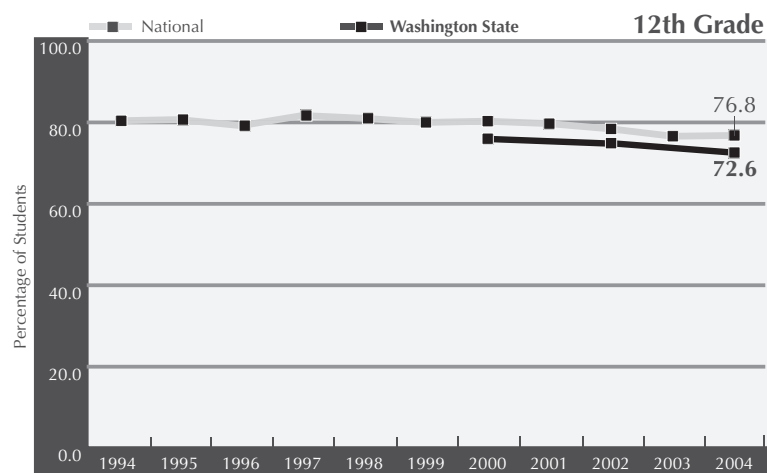


Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

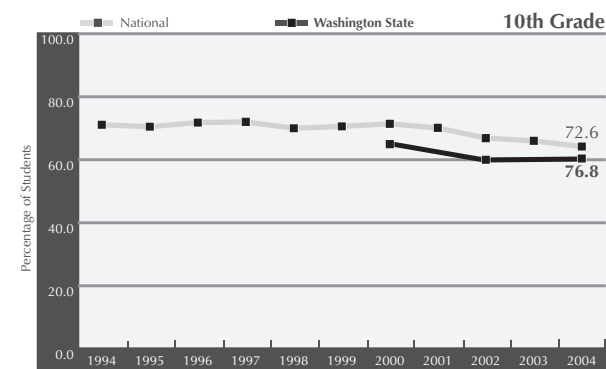
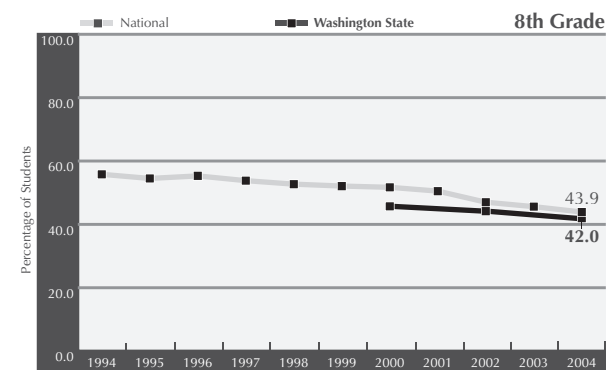
Only 19% of Washington State 10th grade smokers obtain cigarettes by purchasing them. More than 80% of 10th graders obtain them through others. This suggests that there is a culture around smoking that still makes it socially acceptable for others to participate in young people developing a highly dangerous health habit.

The Percentage of Students, Both in Washington and Nationally, Who Have Tried Alcohol is Declining.*

In 1999, underage drinkers (ages 12-20) consumed 19.7% of alcohol consumed in the United States, accounting for \$22.5 billion in total alcohol sales. Roughly half of youth in this age group drink, a proportion similar to that of adults ages 21 and older.¹ The state target to raise the average age of adolescents' first use of alcohol to 16.



Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

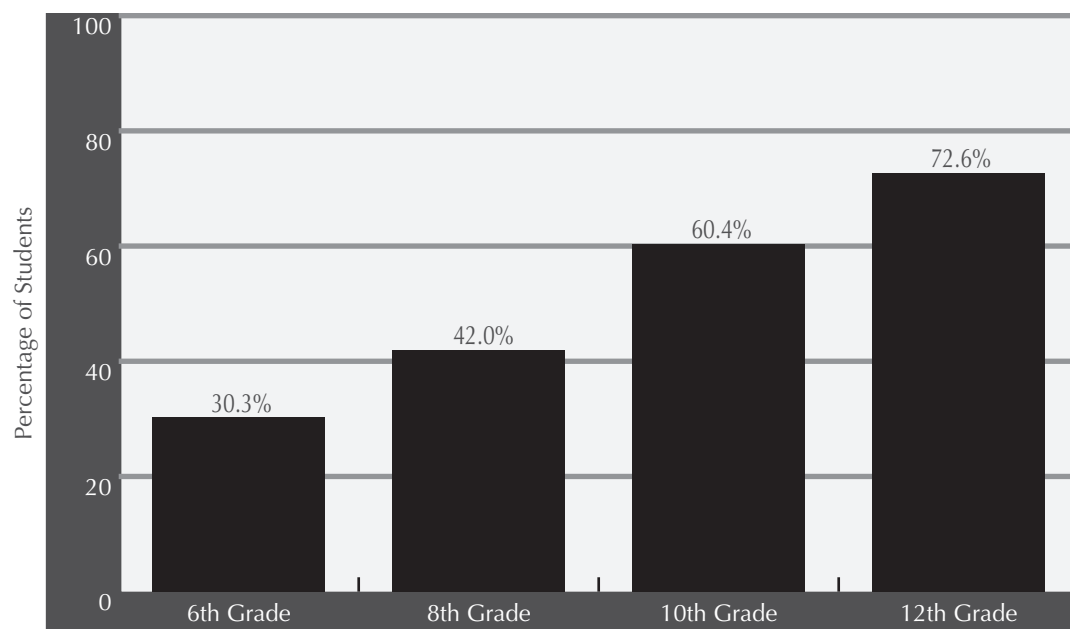


* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

¹ Foster, S., et al. "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association* 289(8), 2003.



Almost a Third of Washington 6th Graders Have Tried Alcohol.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

Teenage drinking can physically damage the brain; interfere with mental and social development; interrupt academic progress; increase chances of risky sexual behavior and teen pregnancy, juvenile delinquency, and crime; compromise health; and result in unintended injury and death.¹

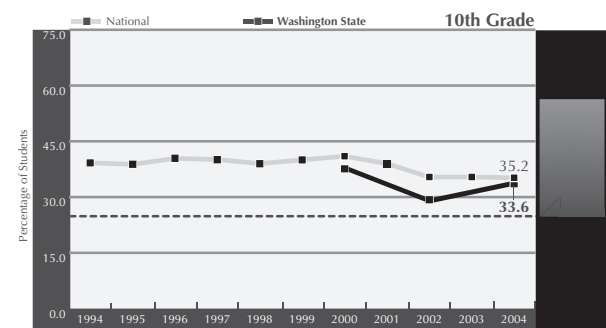
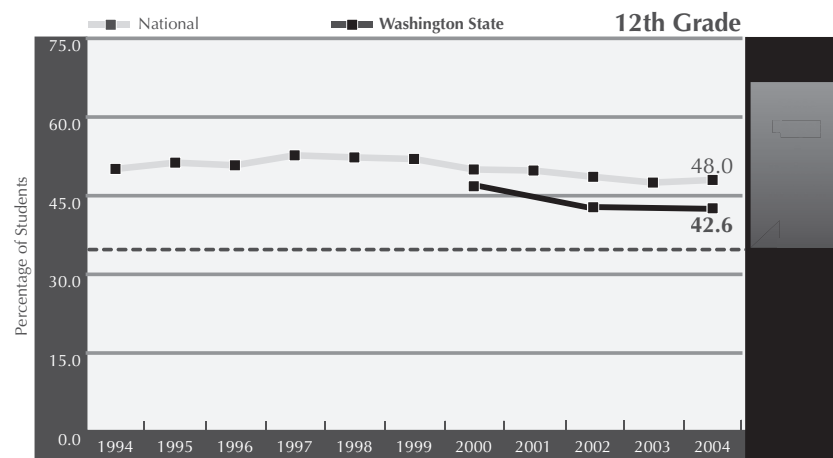
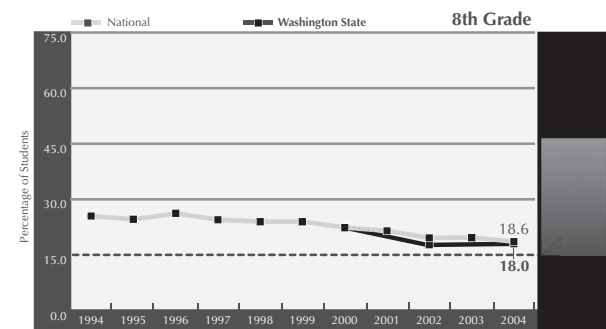
Almost half of Washington students have tried alcohol before they reach high school. Children who begin experimenting with and/or using alcohol at or before 7th grade are significantly more likely at age 23 to be alcohol dependent; use marijuana weekly; sell marijuana; commit felonies; and be arrested.²

¹ Foster, S. et al. "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association* Vol. 289 No. 8, February 26, 2003.

² Ellickson, P., Tucker, J., and Klein, D. "Ten-Year Prospective Study of Public Health Problems Associated with Early Drinking," *Pediatrics* 111(5), 2003.

Use of Alcohol in the Past 30 Days by Washington State 8th, 10th, and 12th Graders Has Levelled Off.*

Recent alcohol use among youth appears to be dropping, both nationally and in Washington State. Research indicates that initiation of alcohol use at an early age increases the risk that teenagers will become heavier drinkers as adults, with alcohol-related problems later in life.¹



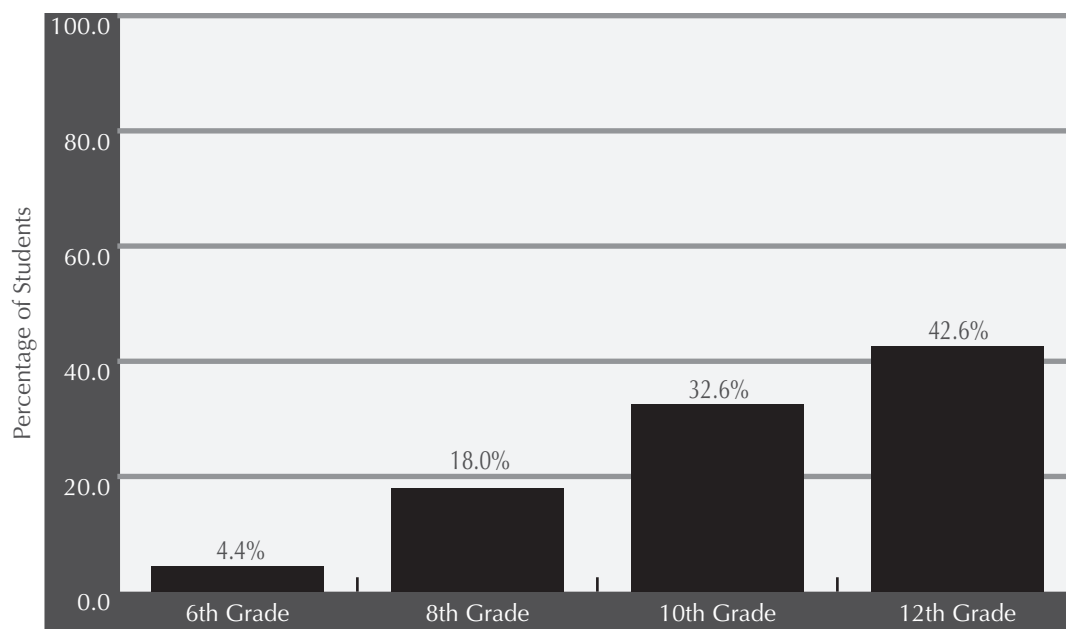
Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

¹ Dewit, D., et al. "Age at First Alcohol Use: A Risk Factor for the Development of Alcohol Disorders," *American Journal of Psychiatry* 157, 2000; Grant, B., and Dawson, D. "Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey," *Journal of Substance Abuse* 9, 1997.



Almost One Out of Five Washington 8th Graders Report Having Used Alcohol in the Past 30 Days.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

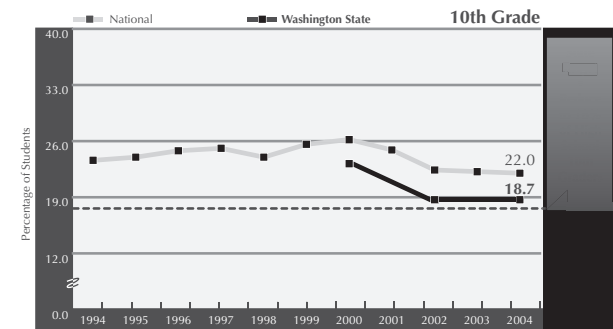
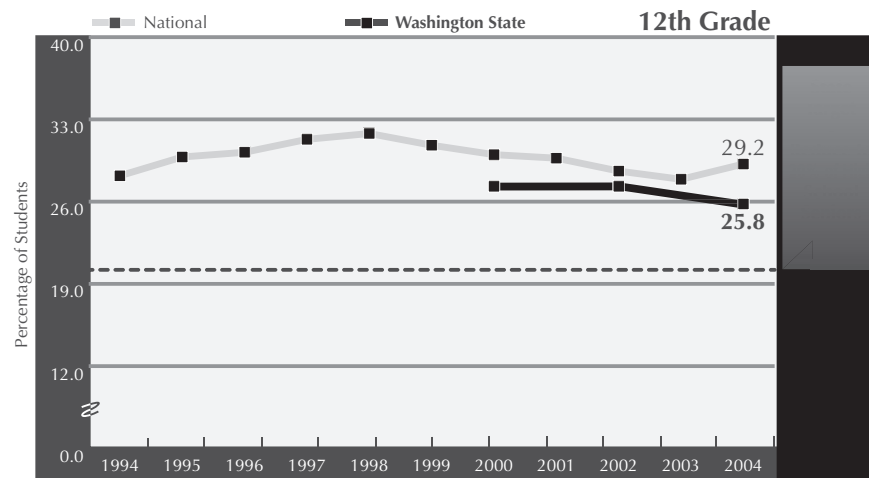
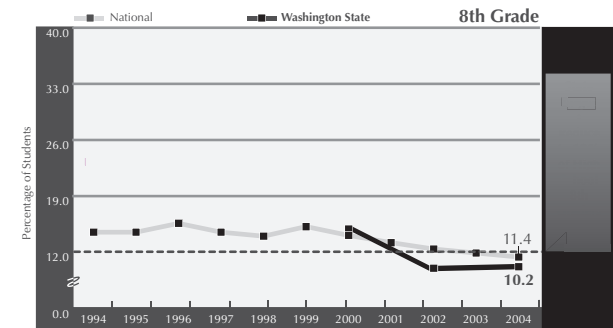
A recent study indicates that youth ages 12-20 are responsible for 19.7% of all alcohol consumed in the United States.¹ Despite the fact that it is illegal, more than 40% of Washington high school seniors report using alcohol in the past 30 days. Teenage drinking is associated with a full range of academic, social, and medical consequences, including juvenile delinquency and crime, risky sexual behavior and teen pregnancy, poor academic progress and school dropout rates, and unintentional injuries and death.²

¹ Foster, S., et al. "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking." *Journal of the American Medical Association* 288 (8), February 26, 2003.

² *Ibid.*

Recent Binge Drinking by Washington State 8th, 10th, and 12th Graders is Leveling Off.*

These graphs indicate that in 2004, the percentage of Washington State students engaging in recent binge drinking saw little decline from the previous survey. Recent binge drinking is defined as having five or more drinks in a row on at least one occasion in the past two weeks. Youth who begin binge drinking at an early age are much more likely to continue as binge drinkers as adults.¹



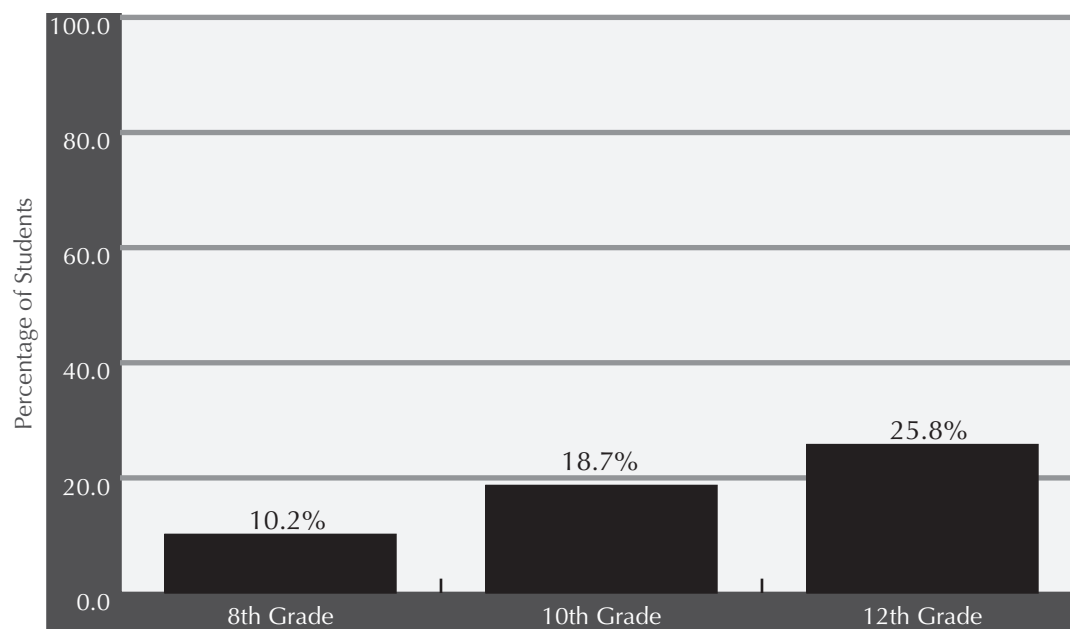
Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

¹ McCarty, C., et. al. "Continuity of Binge and Harmful Drinking from Late Adolescence to Early Adulthood," *Pediatrics* 114(3), 2004.



More Than a Quarter of Washington Seniors Have Engaged in Recent Binge Drinking.

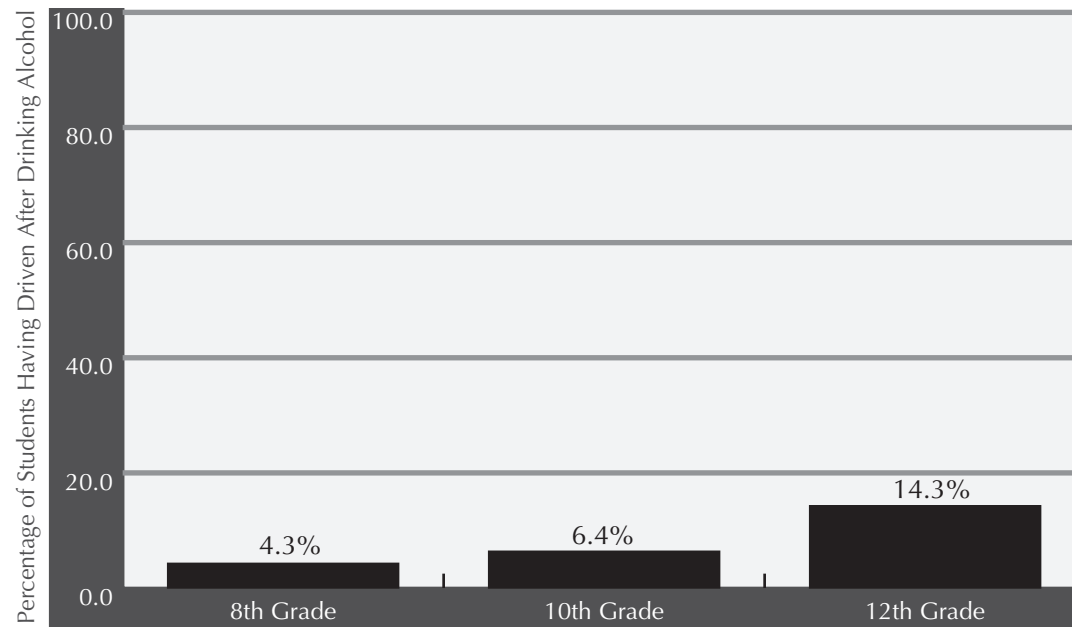


Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

Recent binge drinking is defined as consuming five or more drinks in a row on at least one occasion in the past two weeks. A 2000 survey of Washington students indicates that binge drinking may start as early as the 6th grade, or earlier.¹ Heavy drinking among youth has been linked to motor vehicle crashes and deaths, physical fights, property destruction, poor school and employment performance, and involvement with law enforcement and the legal system.

¹ Office of Superintendent of Public Instruction. *Washington State Survey of Adolescent Health Behaviors – 2000*. Olympia, WA: 2000.

In 2004, Almost 5% of Washington State 8th Graders Had Driven a Vehicle After Drinking Alcohol.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

The *Washington State Healthy Youth Survey* facilitates the cross-tabulation of substance abuse among students with other behaviors in schools and communities. Significant percentages of Washington students in 8th, 10th, and 12th grades have driven after drinking alcohol. This is true even among students too young to possess a drivers license.

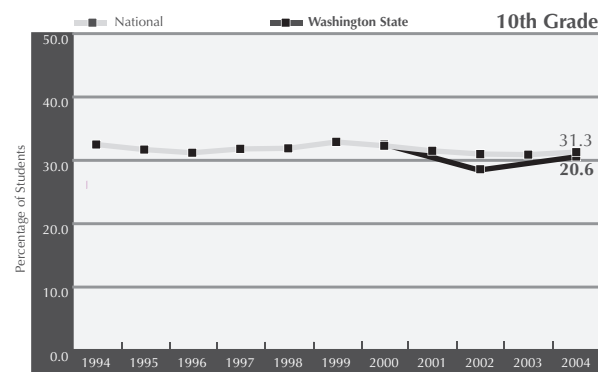
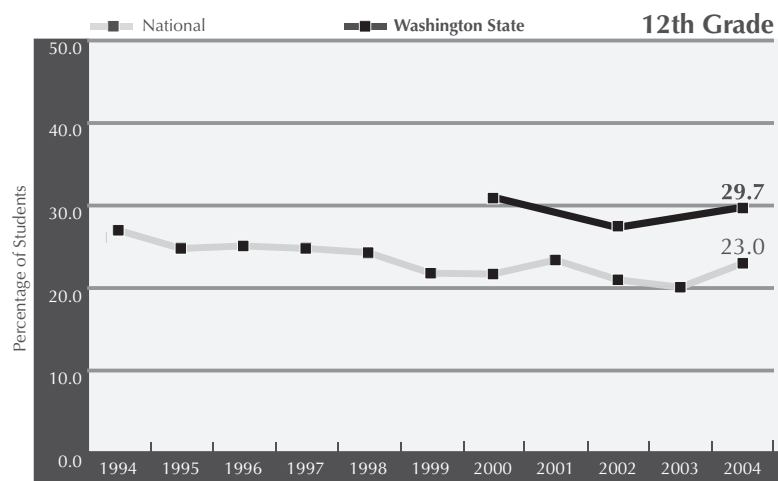
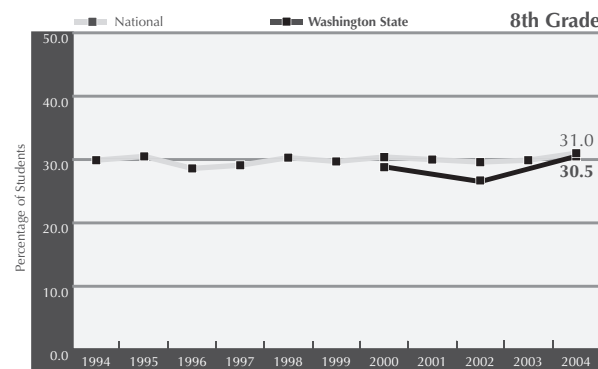
According to the National Highway Traffic Safety Administration, nationally 7,884 drivers ages 15-20 were involved in fatal alcohol crashes in 2003, killing 8,666 people. Some 3,657 of those killed were drivers, nearly a third of whom had been drinking. Motor vehicle fatalities are the leading cause of death among youth ages 8-20.¹

¹ National Highway Traffic Safety Administration. "Parents Who Host Lose the Most: Sample Fact Sheet & Talking Points". Washington, DC: U.S. Department of Transportation, 2005.



About 70% of Washington State 8th, 10th, and 12th Grade Students Do Not Perceive Great Risk from Drinking 1-2 Alcohol Drinks Nearly Every Day.

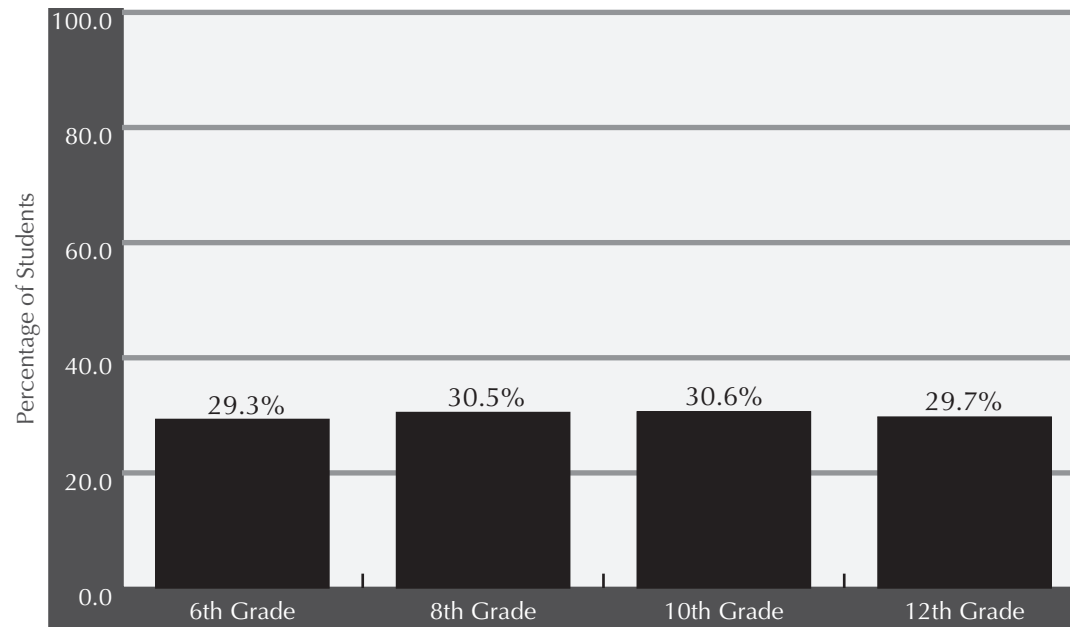
This graph indicates that approximately 70% of Washington 8th, 10th, and 12th grade students do not perceive great risk in near-daily alcohol consumption. National data indicate that student perception of risk regarding both regular use of alcohol and heavy drinking is relatively low, perhaps suggesting a high degree of acceptability of alcohol consumption among students.



Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

Fewer than One Third of Washington State 6th, 8th, 10th, and 12th Graders Perceive Great Risk from Drinking 1-2 Alcohol Drinks Nearly Every Day.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2002*.

Research indicates that attitudes about specific drugs and alcohol are among the most important determinants of actual use.¹ Perception of great risk from near-daily use of alcohol among Washington State students is increasing, but very slowly, and is still a small fraction of the total number of students. Perception of risk also does not increase with age (and hence exposure to anti-alcohol-related programs), likely meaning efforts to increase risk perception are offset by other societal and advertising messages.

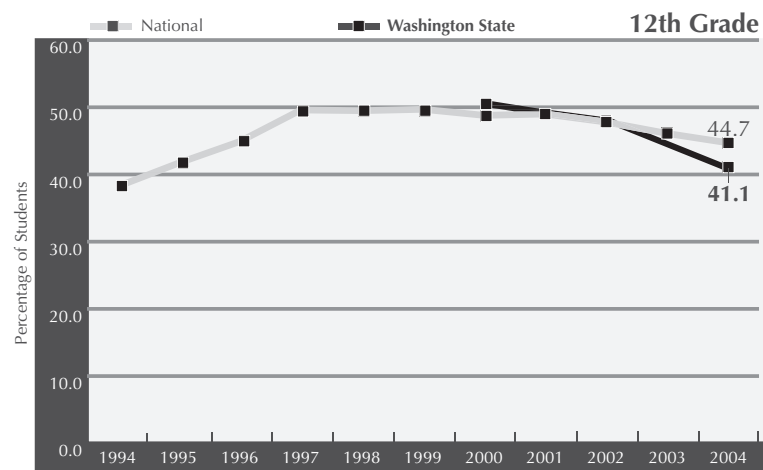
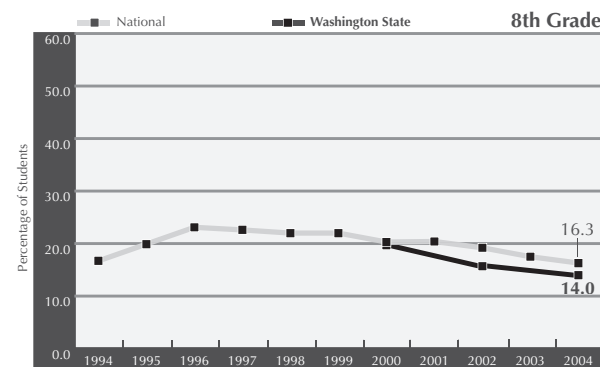
¹ Bachman, J., Johnston, L., and O'Malley, P. "Explaining Recent Increases in Students' Marijuana Use: Impacts of Perceived Risks and Disapproval," *American Journal of Public Health* 88(6), 1988.



The Percentage of Students in Washington State Who Have Tried Marijuana is Declining.*

Besides being associated with a variety of health risks, marijuana use can contribute to risky behaviors and adverse physical and social consequences. Marijuana use among students in Washington State appears to be on the decline. The state target is to raise the average age of adolescents' first use of marijuana to 16.

A 2002 national study indicates that 36% of youth ages 14-17 report they can purchase illegal drugs within five blocks of their home.¹

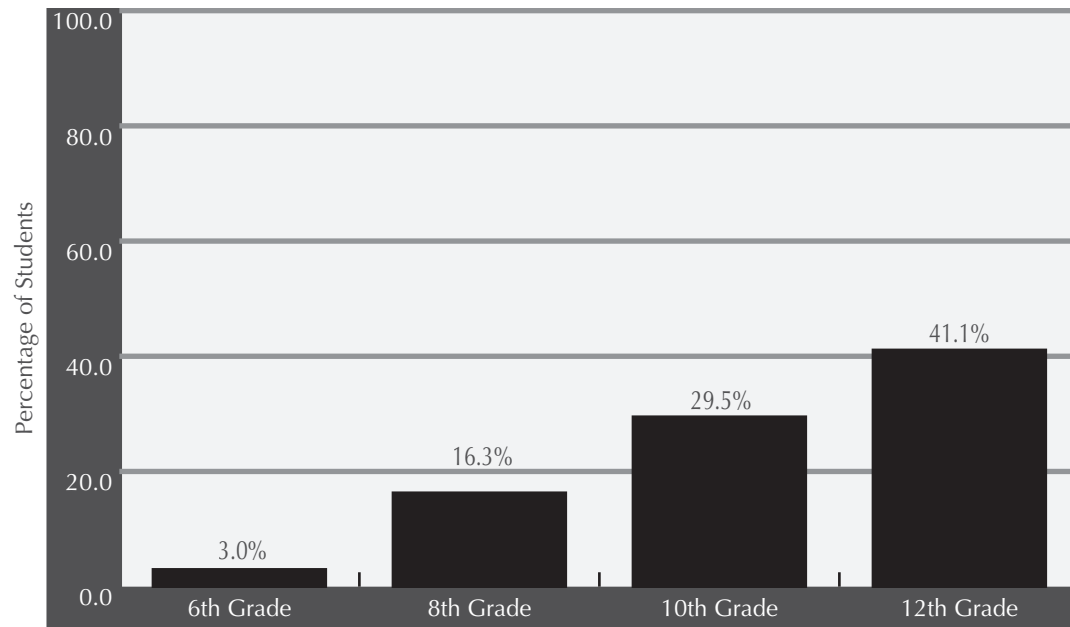


Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

¹ Institute for Adolescent Risk Communication. *Access to Risky Products and Perceptions of Risky Behavior and Popularity*. Philadelphia, PA: University of Pennsylvania, Annenberg Public Policy Center, 2002.

By 12th Grade, About Half of Washington Students Have Tried Marijuana.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

About one fifth of Washington students begin use of marijuana while they are in middle school. A study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) found that substance abuse and addiction nationally added \$41 billion, or 10%, to the cost of elementary and secondary education in 2001 due to class disruption and violence, special education and tutoring, teacher turnover, children being left behind, student assistance programs, property damage, injury, and counseling.

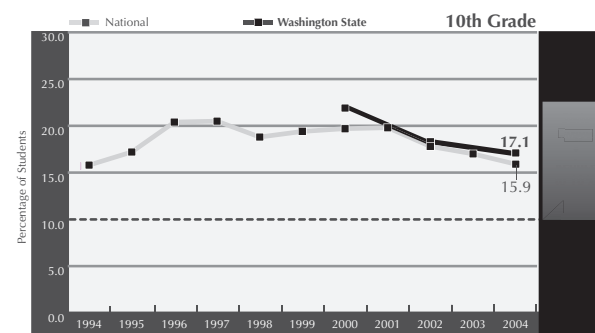
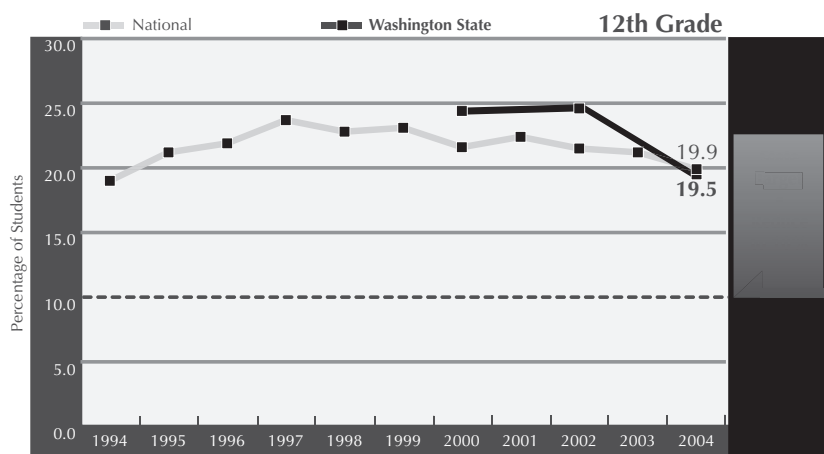
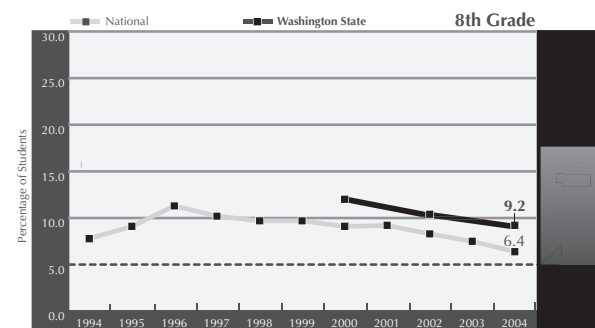
CASA also estimates that 60% of high school students and 30% of middle school students attend schools where illegal drugs are kept, sold, and used. Among 10th graders surveyed, 87% said it was easy to get tobacco, 88% to obtain alcohol, and 78% to get marijuana.¹

¹ *Malignant Neglect: Substance Abuse and America's Schools*. New York, NY: The National Center on Addiction and Substance Abuse at Columbia University, 2001.



Marijuana Use in the Past 30 Days Among Washington State 8th, 10th, and 12th Graders is Declining.*

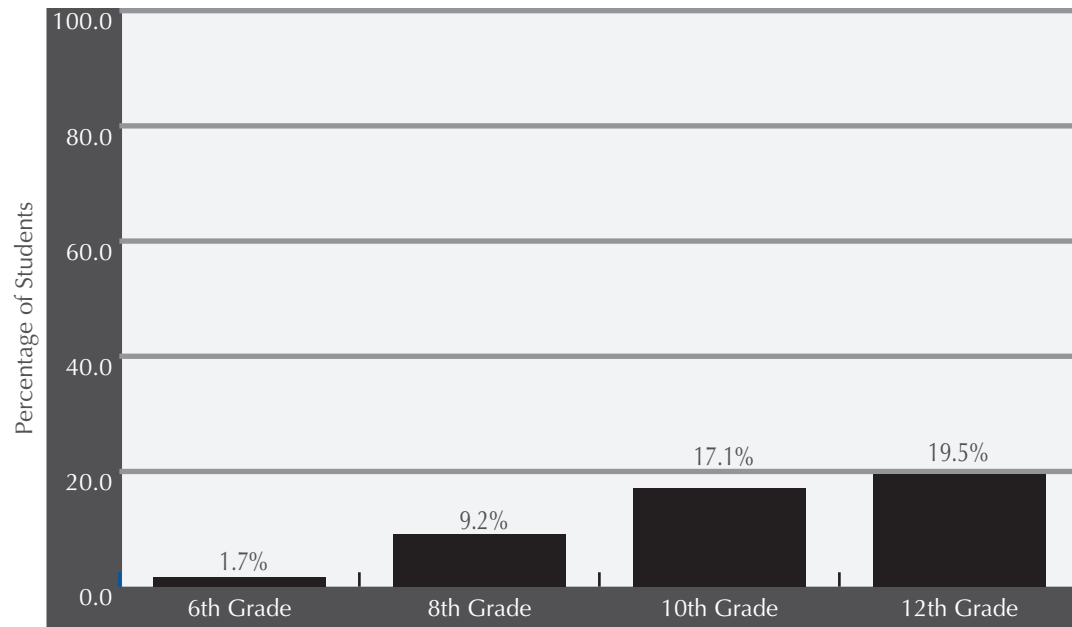
Both nationally and in Washington State, after almost a decade of increases, marijuana use among 8th, 10th, and 12th graders appears to have peaked, and is now beginning to decline.



Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

About One Fifth of Washington High School Seniors Report Having Used Marijuana in the Past 30 Days.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

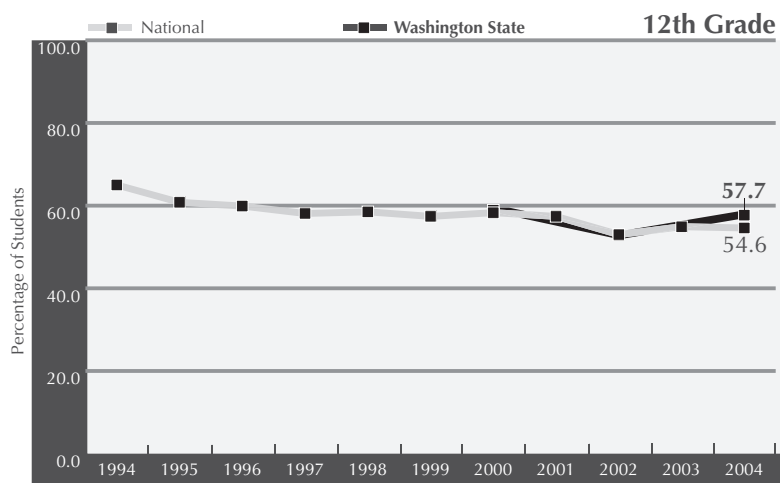
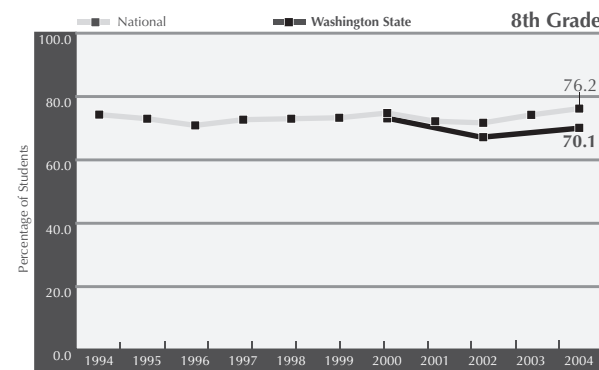
Marijuana use among adolescents follows a predictable pattern, with the highest incidence of use occurring among high school seniors. *Healthy People 2010* recommends a multicomponent approach to youth substance abuse prevention to increase the effectiveness of efforts. Such an approach would include focusing on mobilizing and leveraging resources, raising public awareness, and countering pro-use messages.¹

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-28. Washington, DC: 2000.



The Percentage of 8th, 10th, and 12th Graders Who Perceive Great Risk from Regular Marijuana Use Appears to Have Levelled Off.*

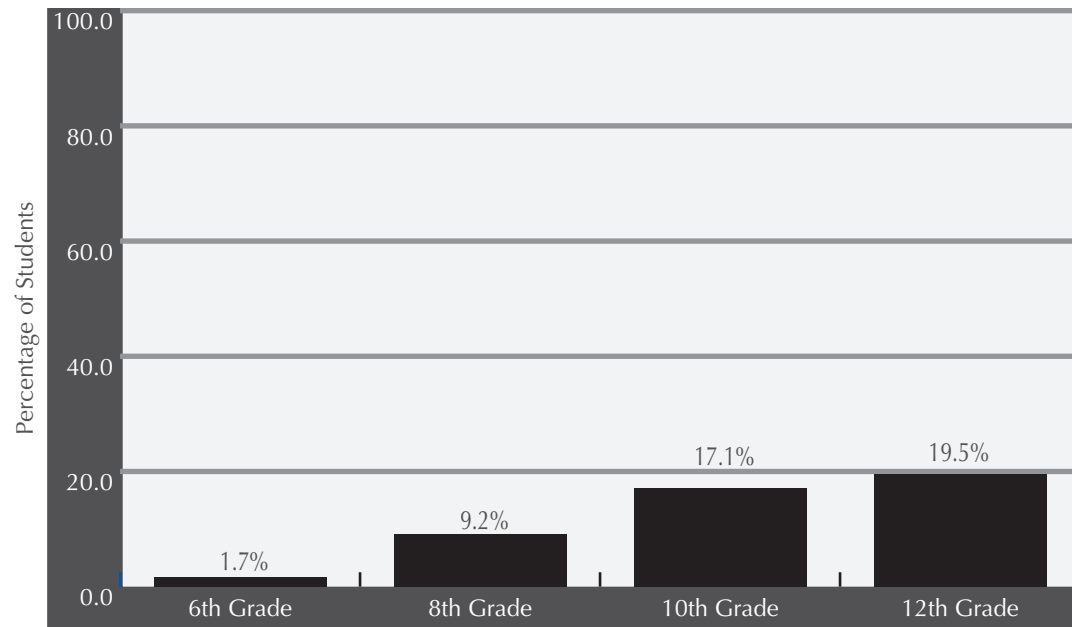
Both nationally and in Washington State, perception of risk from regular marijuana use declines as students get older.



Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

The Percentage of Washington State Students Who Perceive Great Risk from Marijuana Use Declines as They Get Older.

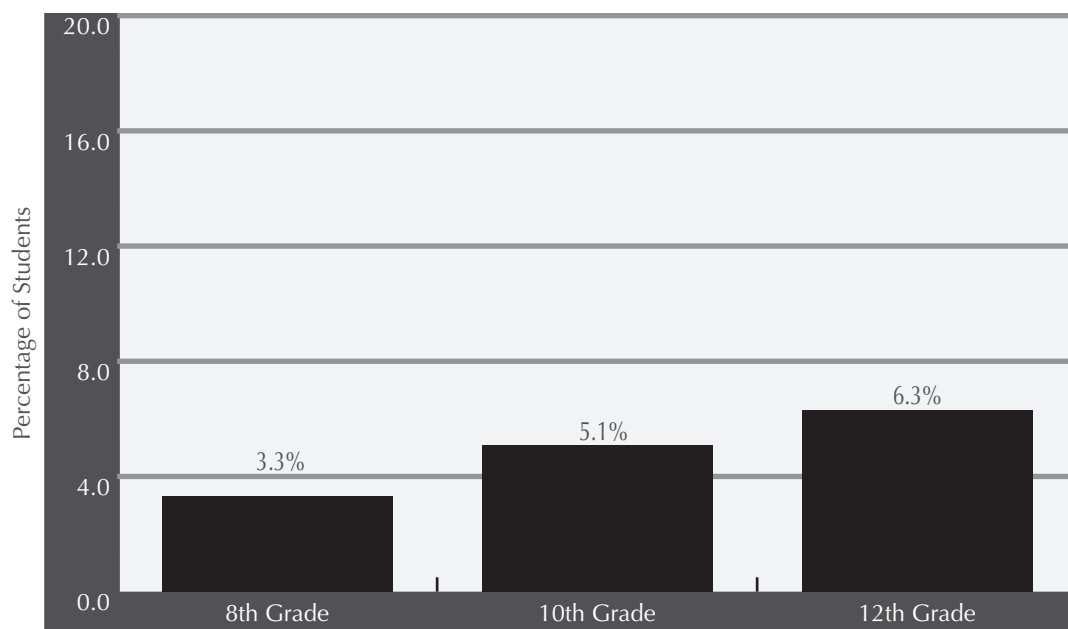


Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

The percentage of students in Washington State and nationally, who perceive great risk from regular marijuana use declines as they get older. This is contrary to the way students perceive the risk of regular cigarette use, which increases with age.



In 2004, More than 6% of Washington State High School Seniors Reported Having Tried Methamphetamine.

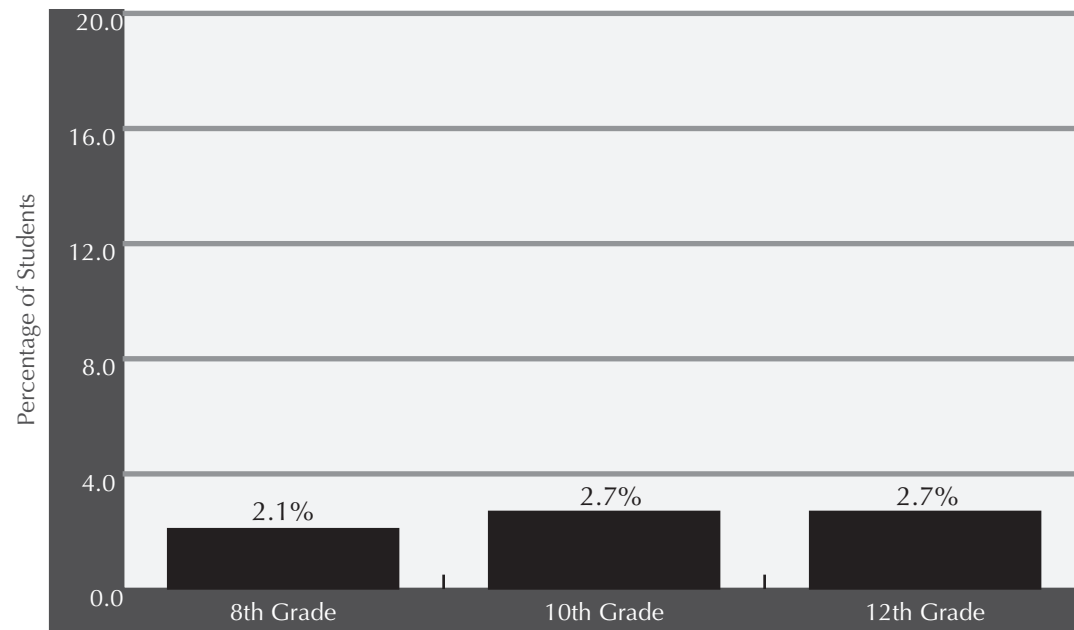


Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

Researchers funded by the National Institute on Drug Abuse have found a range of negative cognitive effects from use of methamphetamine, often associated with brain cell damage. Some of this damage is long-term, and users may not fully recover after they have become abstinent.¹ Recent data from the Washington State Healthy Use Survey suggest that lifetime methamphetamine use among Washington State teenagers may have peaked.

¹ National Institute on Drug Abuse. "Brain Imaging Studies Show Long-Term Damage from Methamphetamine Abuse." *NIDA Notes* 15(3), August 2000; National Institute on Drug Abuse, "Methamphetamine Abuse Linked to Impaired Cognitive and Motor Skills Despite Recovery of Dopamine Transporters," *NIDA Notes* 17(1), April 2002.

In Washington State, Use of MDMA/ Ecstasy Among Washington State 8th, 10th, and 12th Grade Students is Low.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

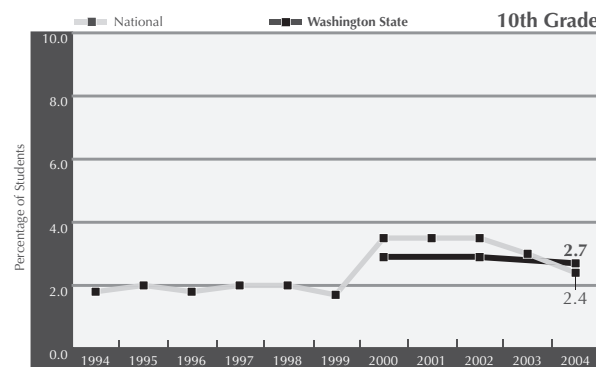
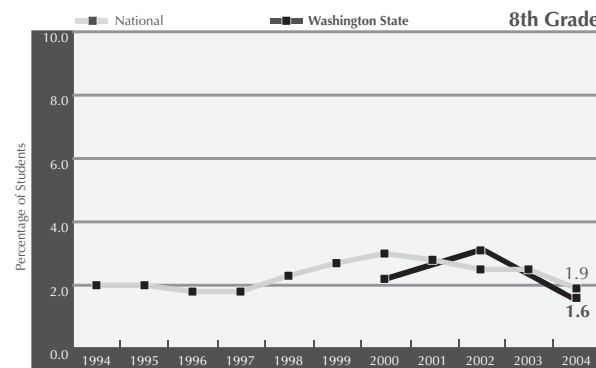
MDMA/Ecstasy, one of a variety of substances called “club” or “party” drugs because of where they are often ingested, has been shown to produce long-lasting damage to the neurons that release serotonin, and may be associated with depression, sleep disorders, anxiety, and memory impairment.¹ The most recent *Healthy Youth Survey* indicates that past 30-day use of MDMA/Ecstasy among Washington youth is on the decline.

¹ National Institute on Drug Abuse. *NIDA Community Drug Alert Bulletin – Club Drugs*, December 1999.



Both Nationally and in Washington State, Steroid Use by Students Seems to Be Declining.*

Behavioral and health problems associated with steroid use include suicides, homicides, liver damage, and heart attacks.¹ Use of steroids in Washington State appears to be declining in all grades.

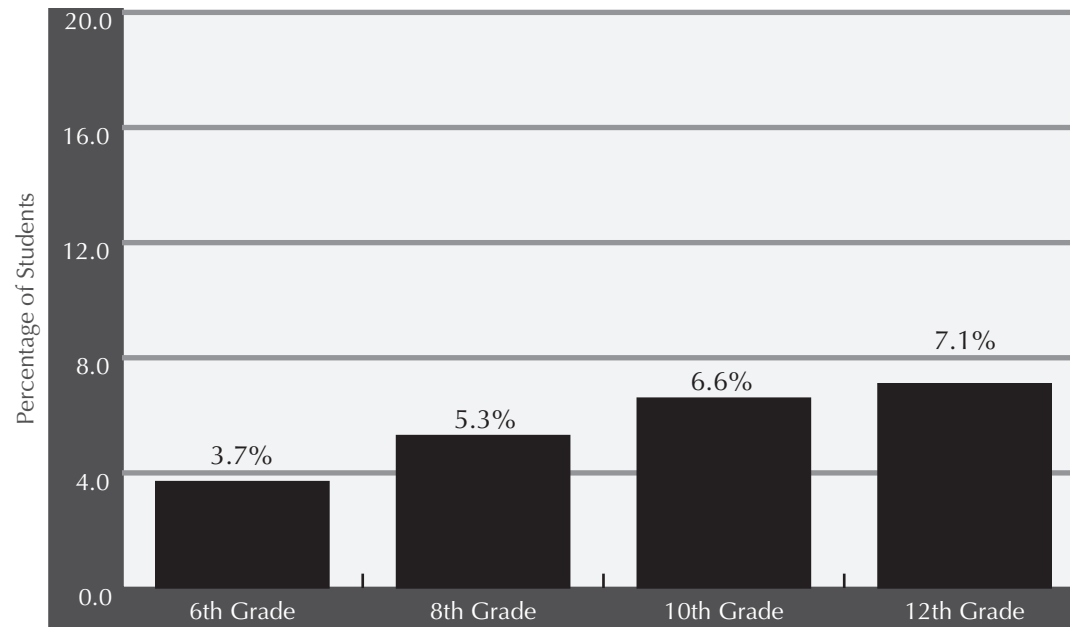


Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-36. Washington, DC: 2000.

Almost 4% of Washington State 6th Graders Have Used Inhalants in Their Lifetimes.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

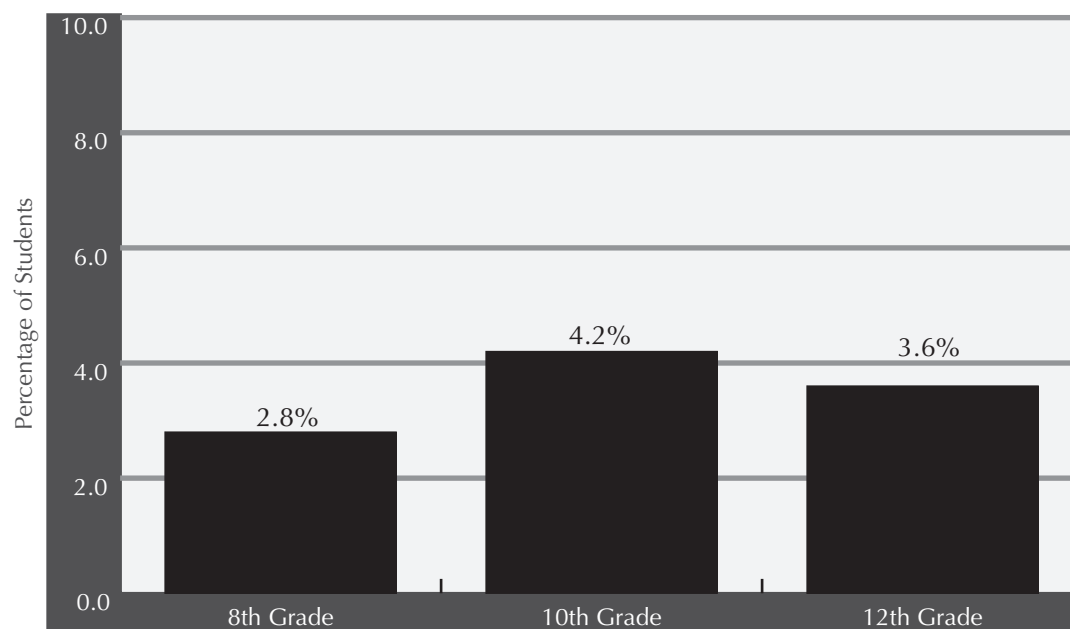
Inhalants are substances whose vapors can be inhaled to produce a mind-altering effect. These include volatile solvents (paint thinners, degreasers, and glue); aerosols (hair sprays and vegetable oil sprays); ether, nitrous oxide, and propane; and nitrites. A single, prolonged session of inhalant use can produce rapid and irregular heart rhythms, heart failure, and death. Chronic exposure can cause widespread and long-lasting damage to the nervous system and other vital organs.¹

It appears that inhalant use by Washington State students peaks among 8th graders, and declines thereafter.

¹ National Institute on Drug Abuse. "Facts About Inhalant Abuse," *NIDA Notes* 15(6), January 2001.



In 2004, More than 4% of Washington State 10th Graders Reported Using Ritalin Illicitly in the Past 30 Days.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

Illicit use of Ritalin by high school students nationwide appears to be on the increase. A recent study found that 10% of youth ages 12-17 had abused Ritalin (and Adderall) at least once. The euphoria produced by excessive, intranasal, or intravenous use of Ritalin is similar to that produced by cocaine and other amphetamines. High doses can lead to delirium, hallucination, and toxic psychosis.¹

Concern regarding the abuse of Ritalin is part of a larger concern about the growing abuse of prescription drugs, especially by teens, which tripled between 1992 and 2003.²

¹ The National Center on Addiction and Substance Abuse at Columbia University (CASA). *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the United States*. New York, NY: CASA, July 2005.

² Ibid.

Peer Substance Abuse Has Significant Negative Impacts on School Performance.



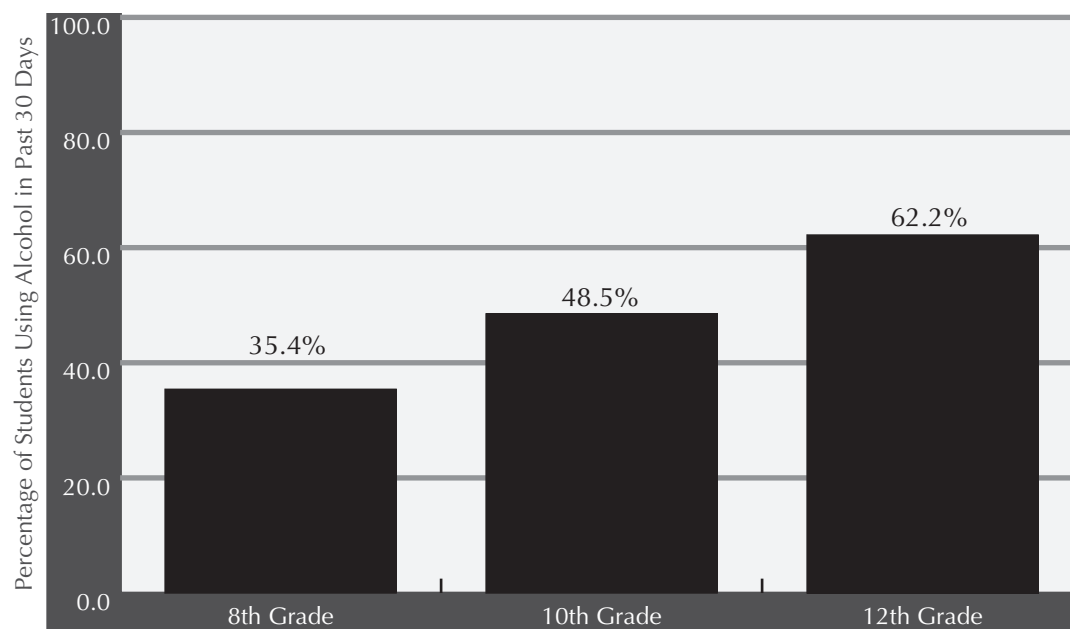
In a study undertaken by Washington Kids Count at the University of Washington's Human Services Policy Center, data from the results of the 1999 Washington Assessment on Student Learning tests were linked with the results of the 1998 Washington Survey of Adolescent Health Behaviors administered in Washington schools. Peer substance use was calculated as the average level of alcohol or drug use by students of the same age, gender, and race-ethnic group in the school.

Among middle schoolers:

- *Students whose peers had little or no involvement with drinking and drugs scored substantially higher than students whose peers had a low level of drinking or drug use.*
- *The entire average difference in whether or not students met the state reading and math standards was accounted for by the degree to which their peers used alcohol or other drugs.*
- *The most important factors reliably indicating the level of substance abuse in a school are whether students start antisocial behavior at an early age, whether the prevailing attitudes of the students condone or condemn antisocial behavior, and whether students have opportunities for productive involvement in school and community activities.¹*



Students Who Report Poor Grades are More Likely to Have Used Alcohol in the Past 30 Days.



Source: Office of Superintendent of Public Instruction, *Washington State Healthy Youth Survey – 2004*.

The *Washington State Healthy Youth Survey* allows for the cross-tabulation of substance abuse among students with other behaviors in schools and communities. Alcohol use in the past 30 days is associated with self-reported poor grades (grades last year mostly Ds and Fs). In 2004, of 10th graders reporting poor grades, 15.1% used alcohol ten or more times in the past 30 days. This association begins early, with 7.3% of 6th graders reporting poor grades having used alcohol in the past 30 days.

The Problem: Substance Abuse Prevalence & Trends

PREVALENCE

Adolescent
Substance
Use and Beliefs

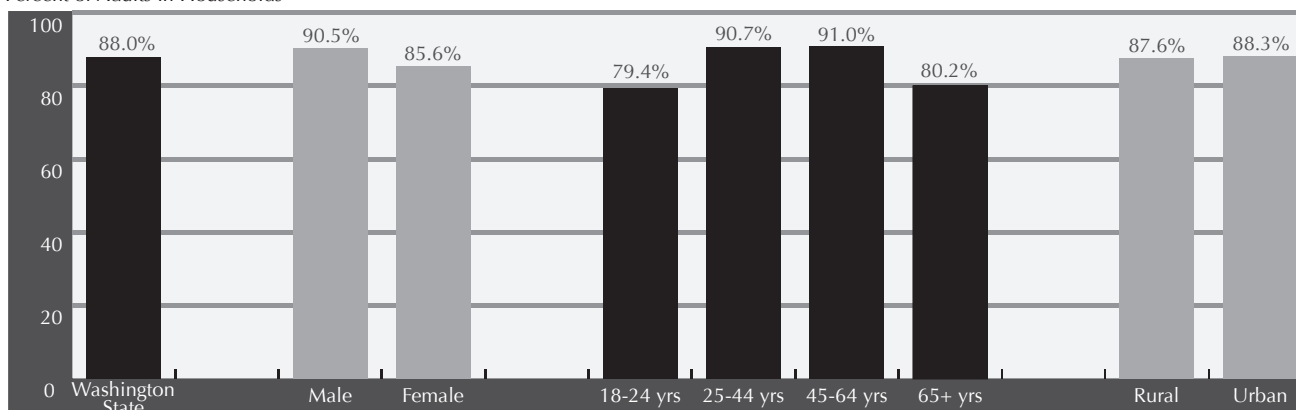
Adult
Substance
Use



Males and Those Ages 25-44 Have Higher Rates of Alcohol Use.

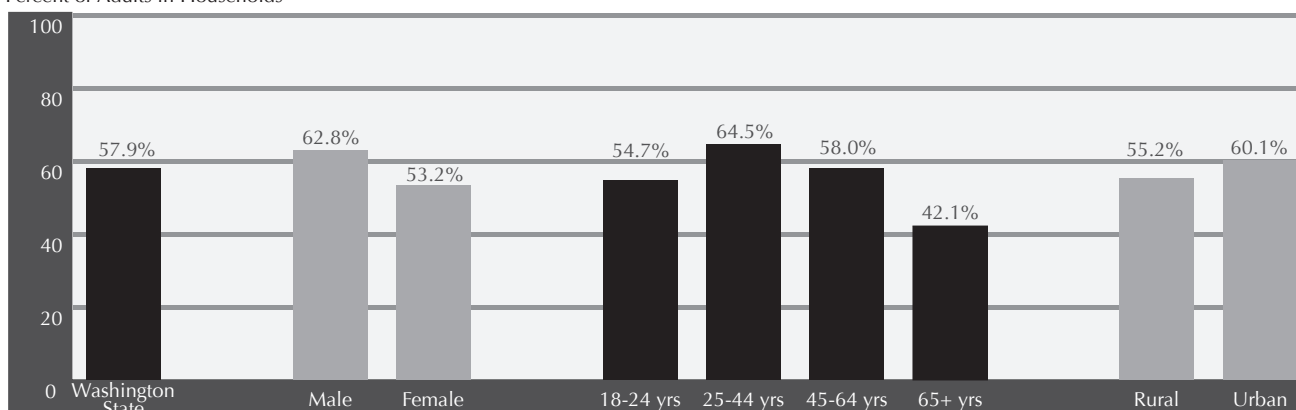
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30-Day Use of Alcohol

Percent of Adults in Households



Source: *Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.

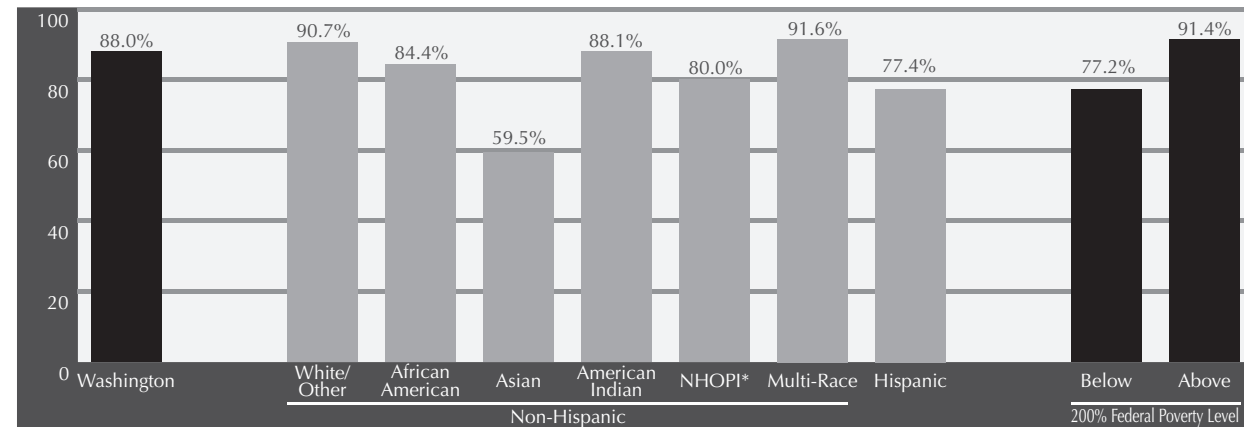
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

Asian-Americans, Hispanics, and Lower-Income Individuals Have Lower Rates of Alcohol Use.



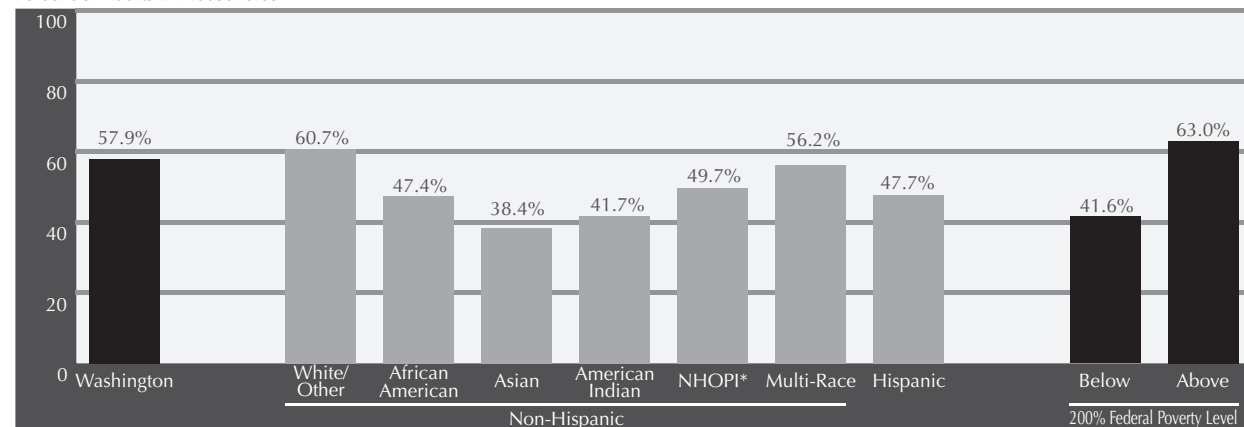
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30-Day Use of Alcohol

Percent of Adults in Households



*Native Hawaiian or Pacific Islander

Source: Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.

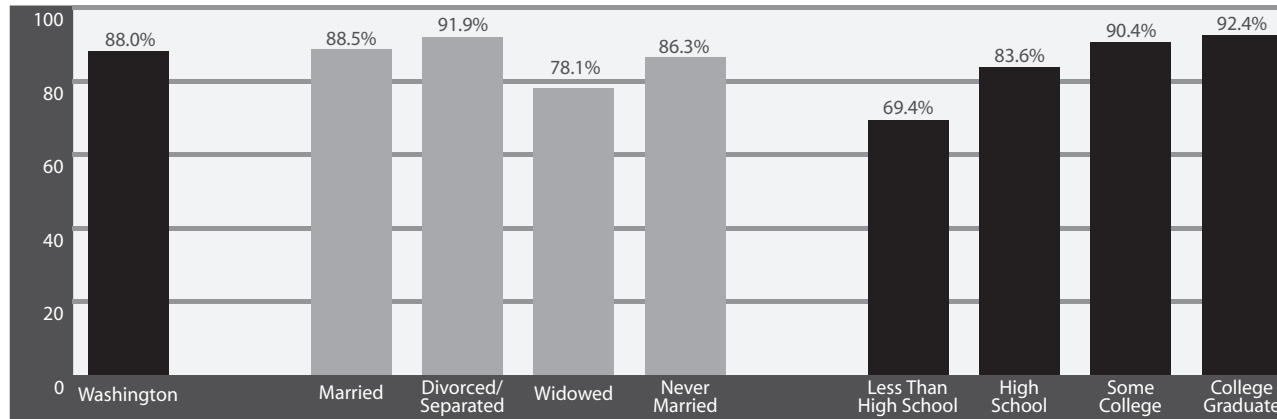
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.



Widowed Individuals and Those Who Never Completed High School Have Lower Rates of Alcohol Use.

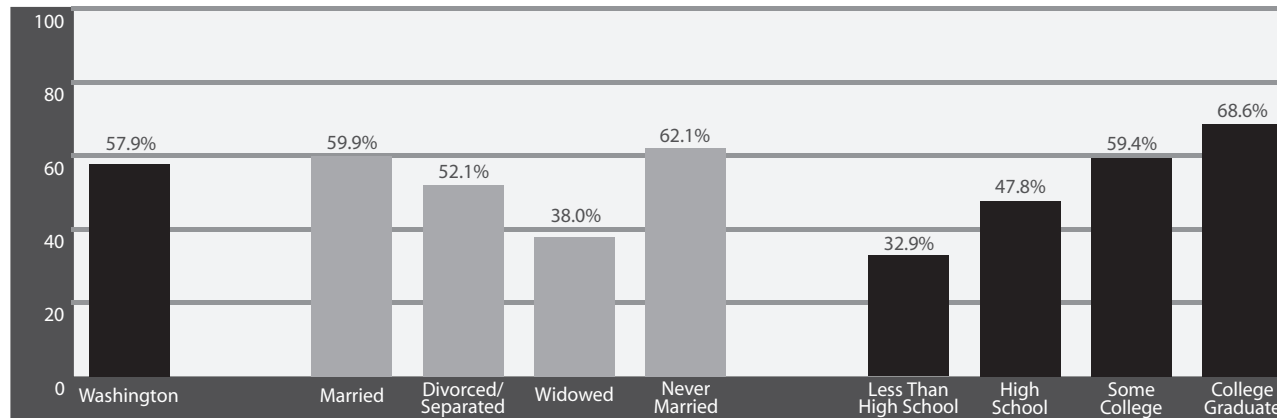
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30-Day Use of Alcohol

Percent of Adults in Households



Source: *Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

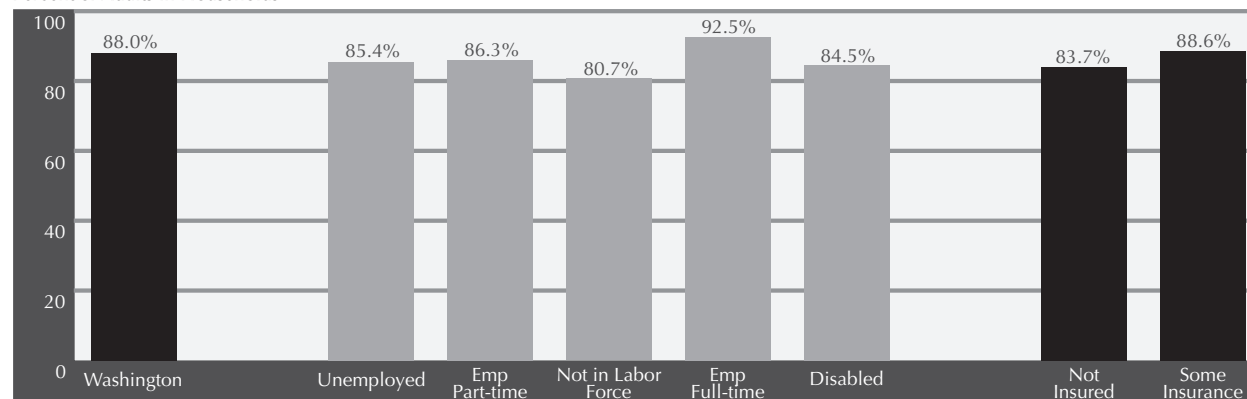
Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
 Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

Individuals Not in the Labor Force and Disabled, or Who are Without Health Insurance are Less Likely to Have Used Alcohol in the Past 30 Days.



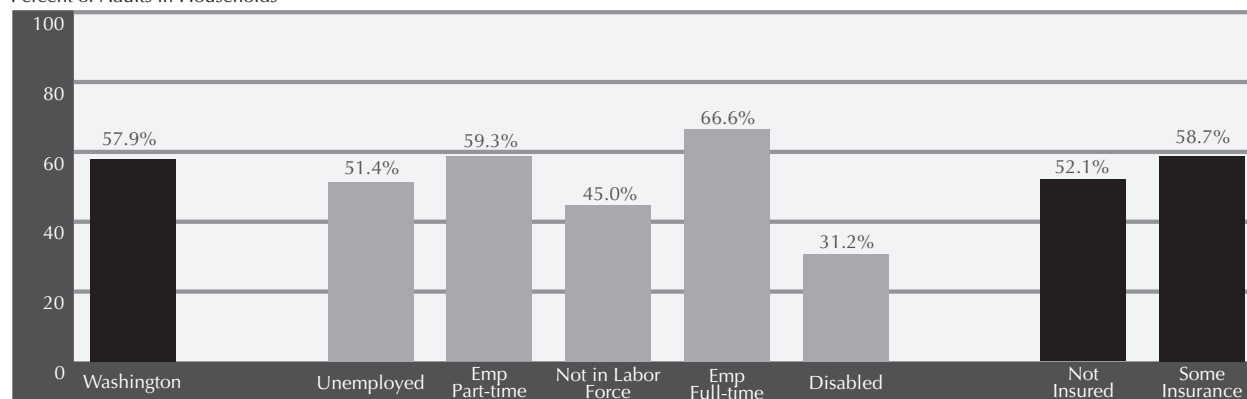
Lifetime Use of Alcohol

Percent of Adults in Households



Past 30-Day Use of Alcohol

Percent of Adults in Households



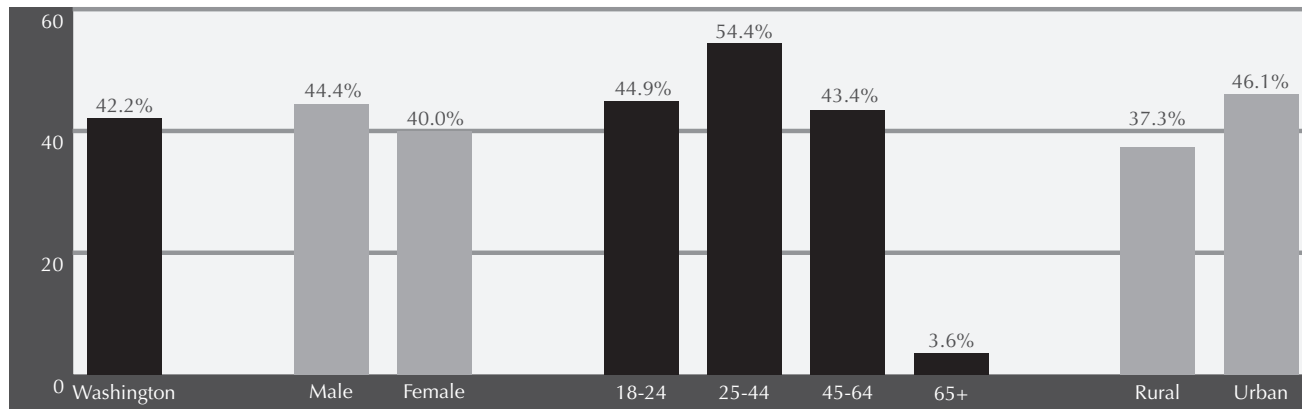
Source: Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.



Individuals Over 65 and Rural Residents Have Lower Rates of Marijuana Use.

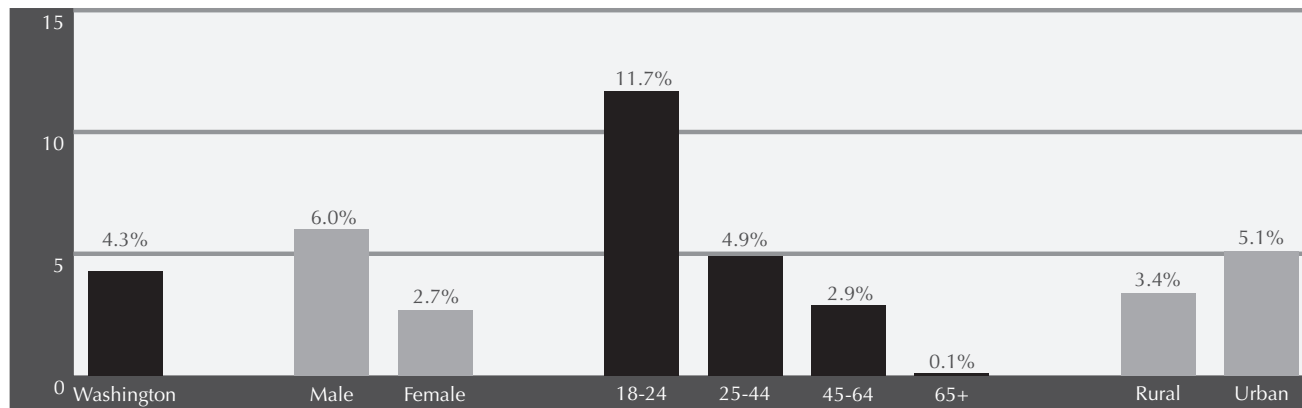
Lifetime Use of Marijuana

Percent of Adults in Households



Past 30-Day Use of Marijuana

Percent of Adults in Households



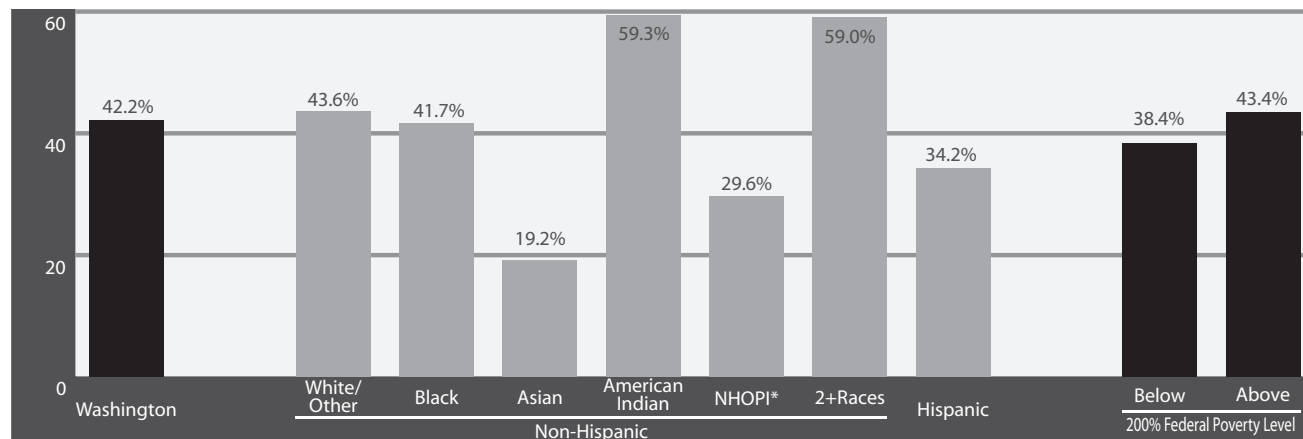
Source: Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

Asian-Americans and Native Hawaiians/ Pacific Islanders Have Lower Rates of Marijuana Use.



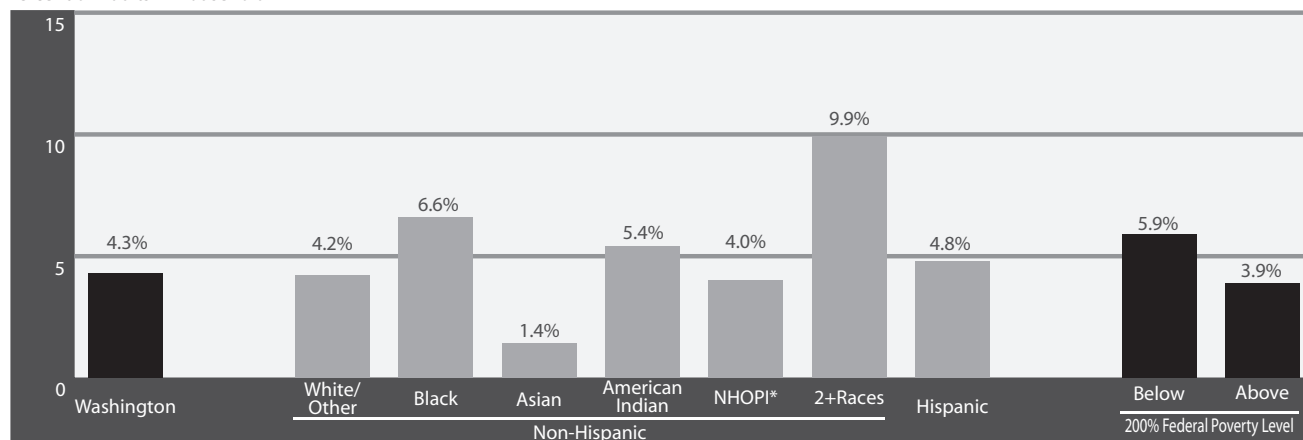
Lifetime Use of Marijuana

Percent of Adults in Household



Past 30-Day Use of Marijuana

Percent of Adults in Household



*Native Hawaiian or Pacific Islander

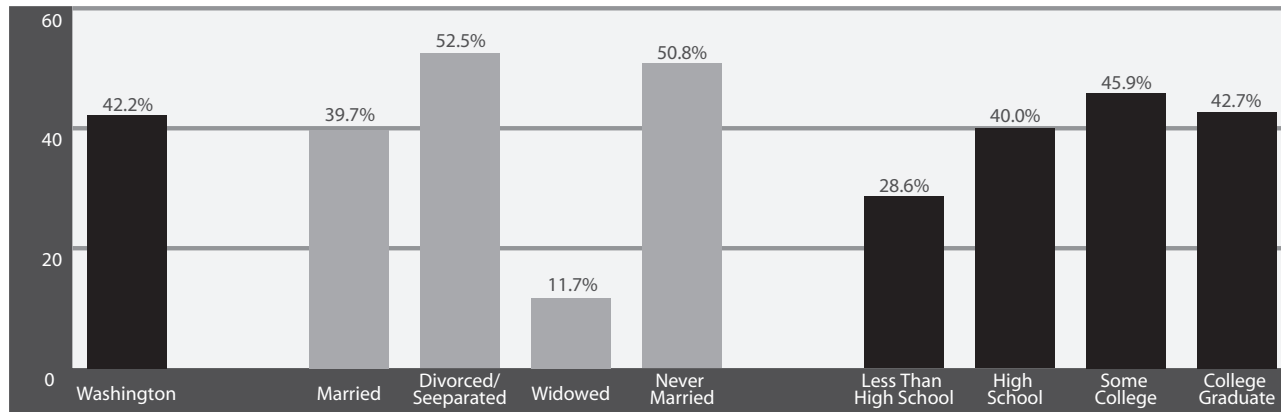
Source: Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.



Widowed Individuals and Those Who Never Completed High School Have Lower Rates of Marijuana Use.

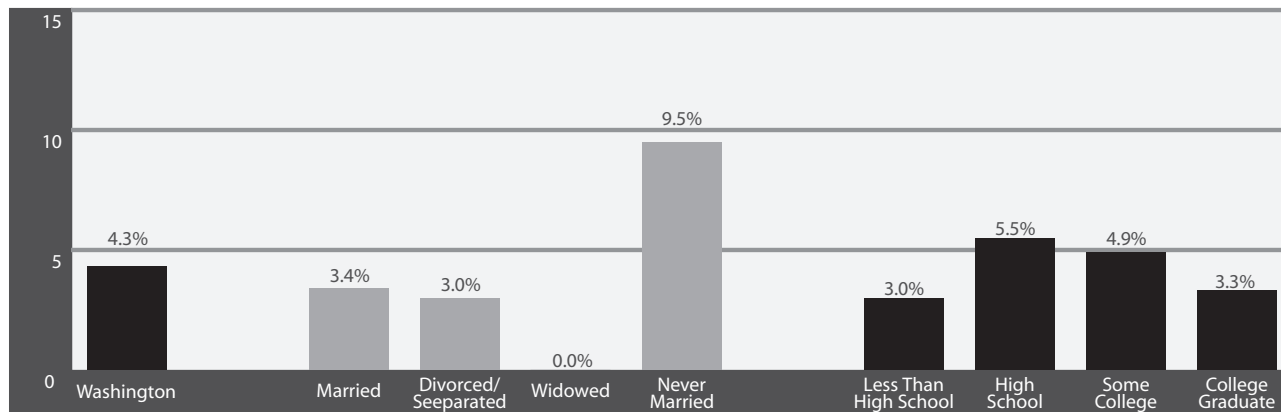
Lifetime Marijuana Use

Percent of Adults in Households



Past 30-Day Use of Marijuana

Percent of Adults in Households



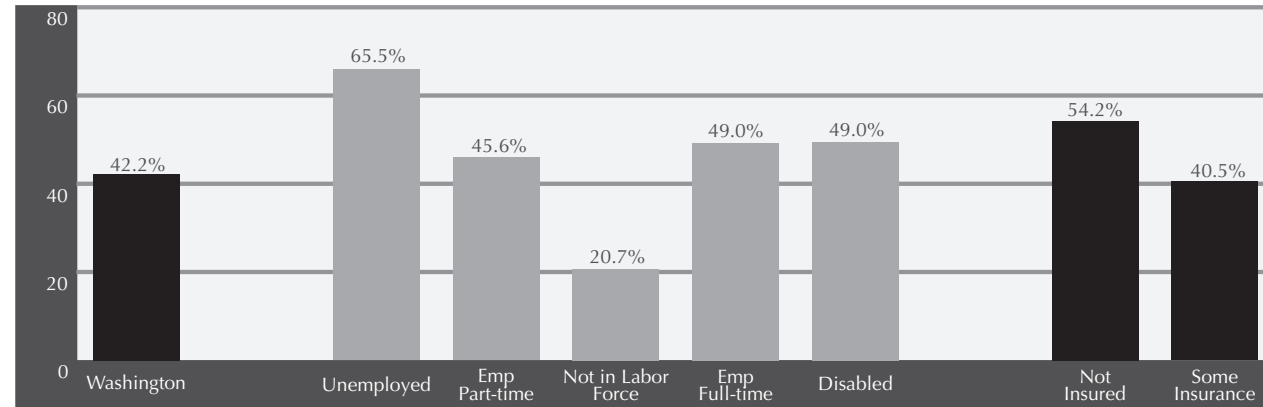
Source: Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

Individuals Not in the Labor Force, and Those With Health Insurance are Less Likely to Have Used Marijuana in the Past 30 Days.



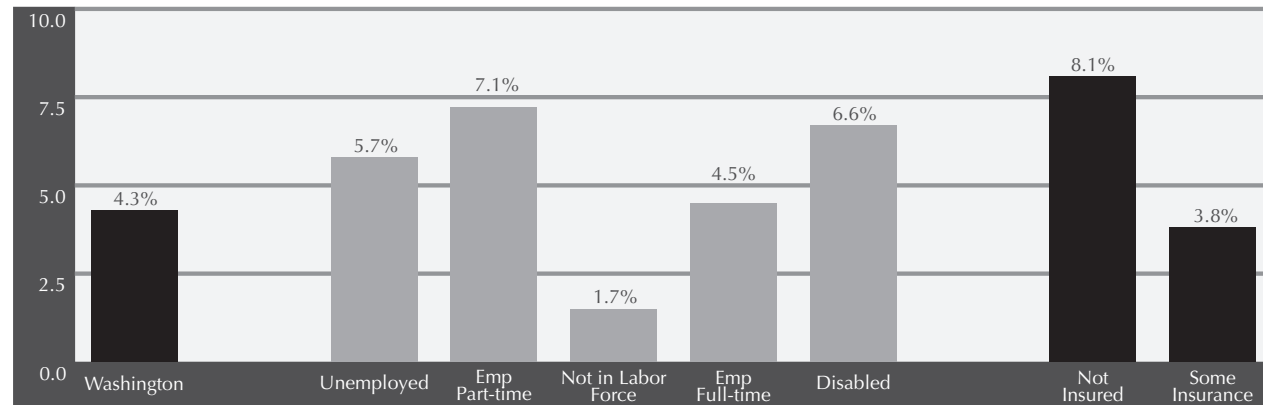
Lifetime Marijuana Use

Percent of Adults in Households



Past 30-Day Use of Marijuana

Percent of Adults in Households



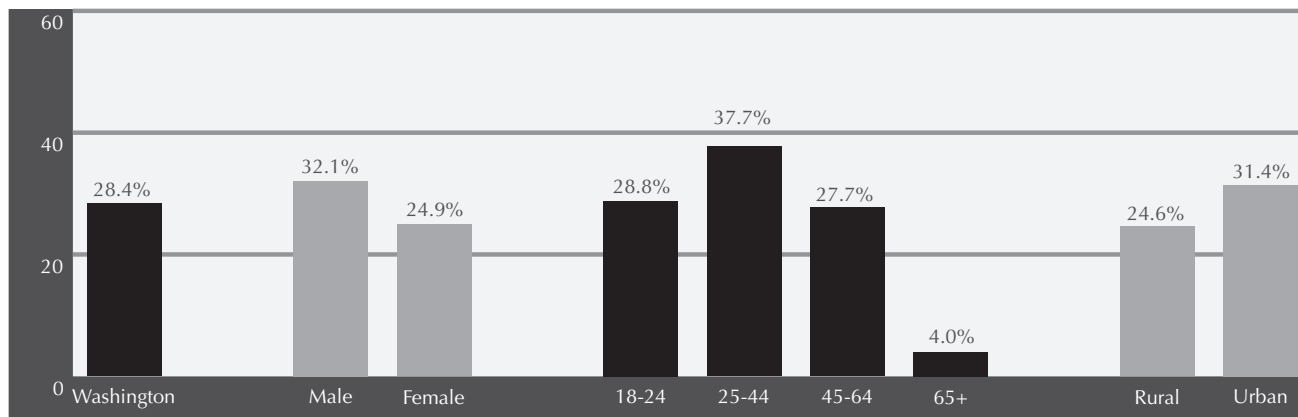
Source: Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.



Individuals Over Age 65 and Rural Residents Have Lower Rates of Use of Illicit Drugs Other than Marijuana.*

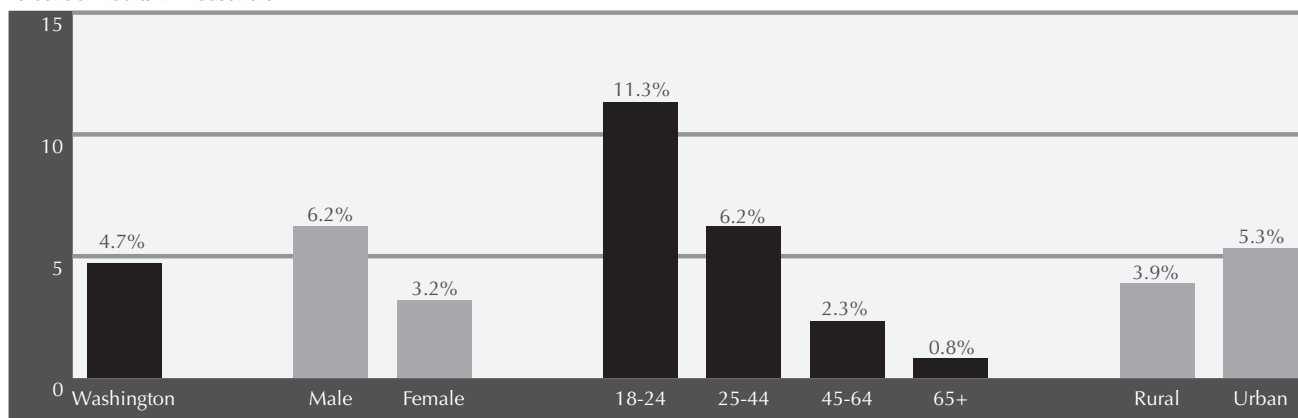
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Household



Past 12-Month Use of Illicit Drugs Other than Marijuana

Percent of Adults in Household



Source: Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

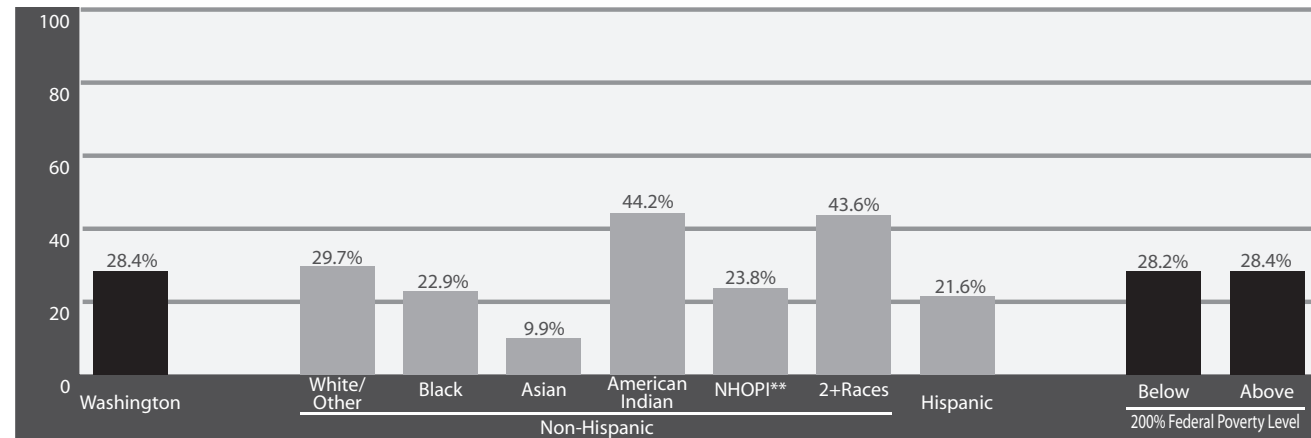
* Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.

American Indians and Multi-Race Individuals Have Higher Rates of Use of Illicit Drugs Other than Marijuana.*



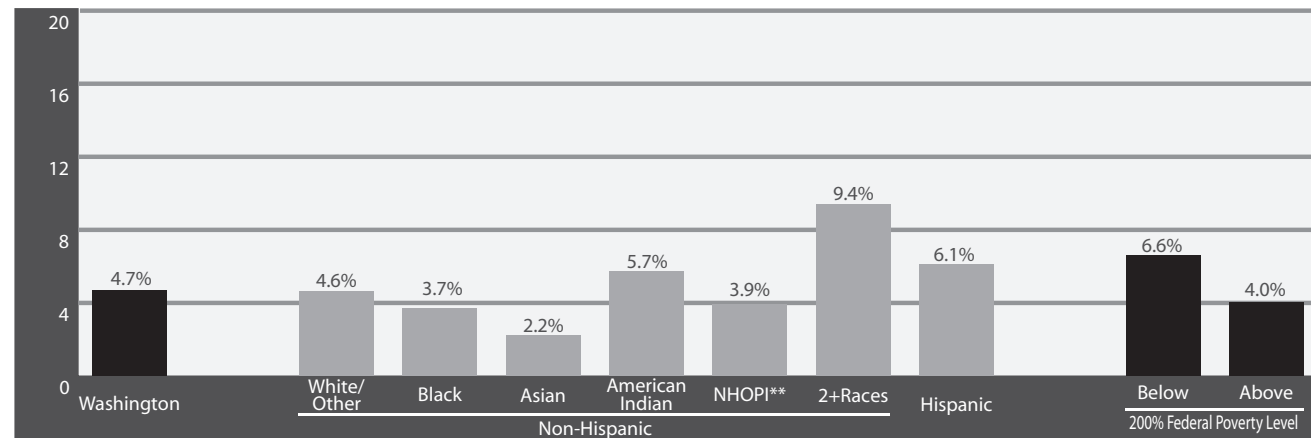
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Household



Past 12-Month Use of Illicit Drugs Other than Marijuana

Percent of Adults in Household



**Native Hawaiian or Pacific Islander

Source: Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

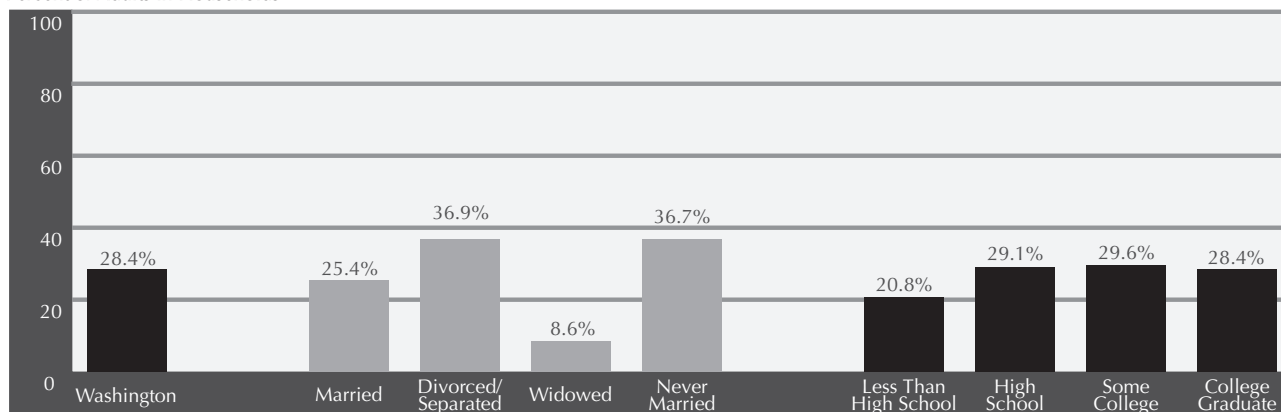
* Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.



Widowed Individuals and Those Who Never Graduated from High School Have Lower Rates of Use of Illicit Drugs Other than Marijuana.*

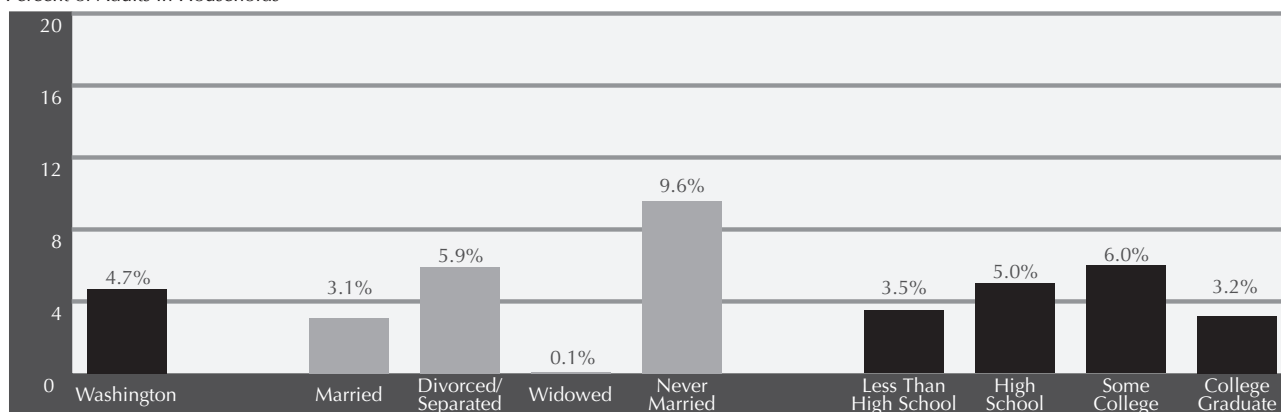
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Past 12-Month Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Source: Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

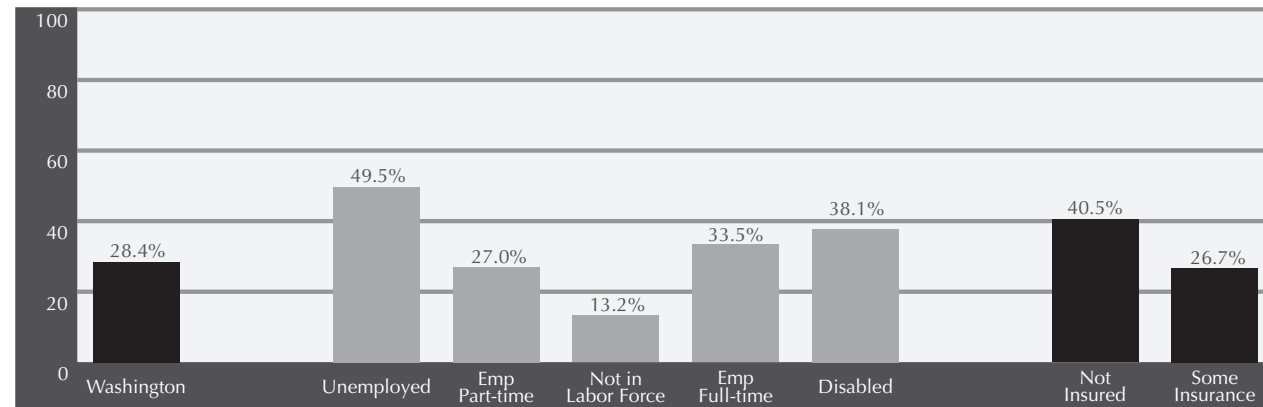
* Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.

Individuals Who are Unemployed, Disabled, and Lack Health Insurance Have Higher Rates of Use of Illicit Drugs Other than Marijuana.*



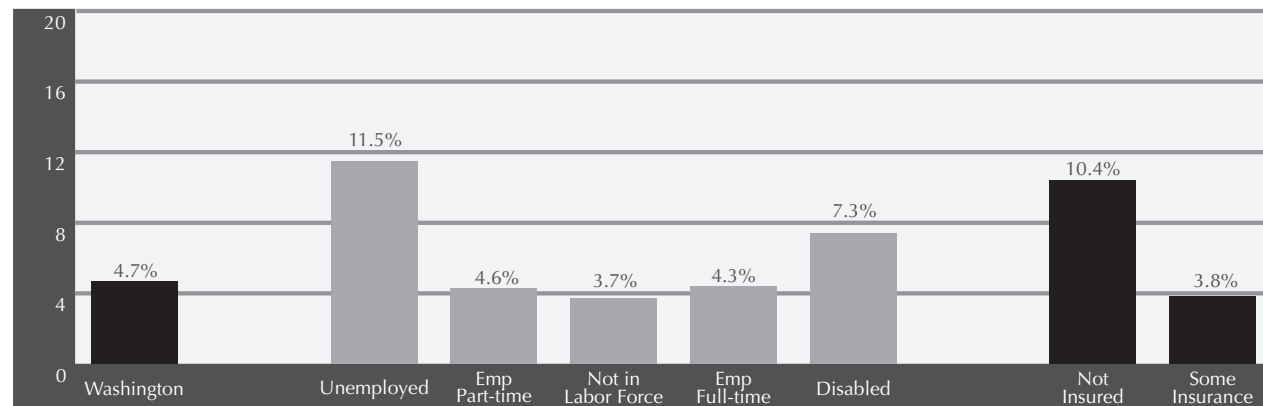
Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households



Past 12-Months Use of Illicit Drugs Other than Marijuana

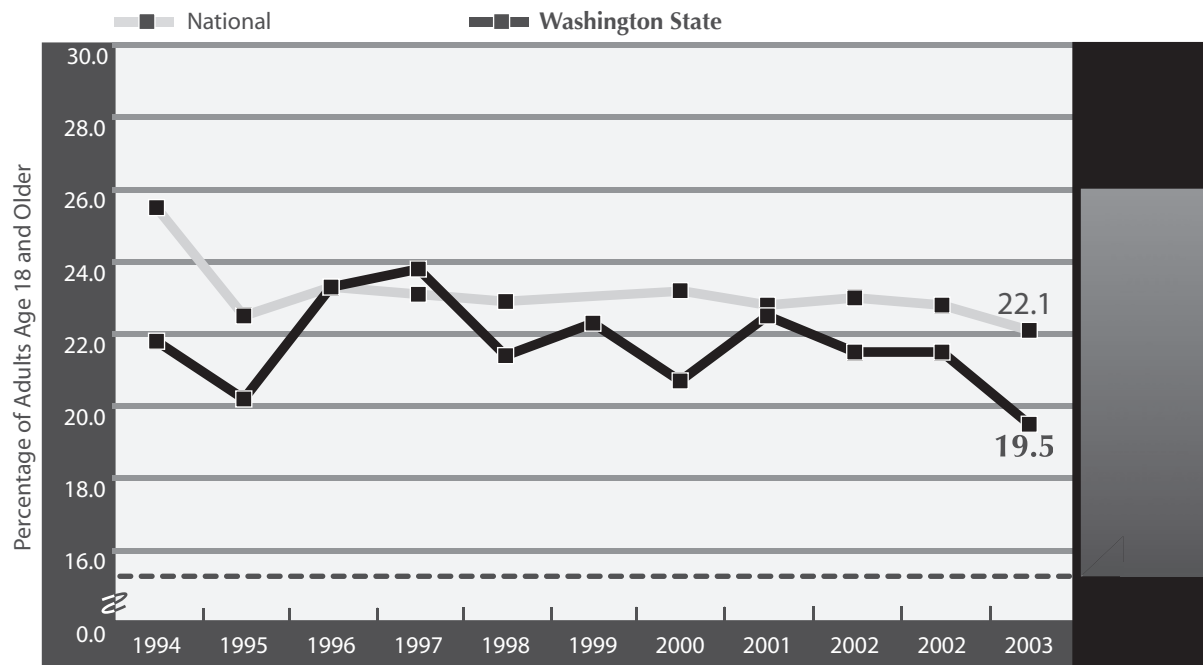
Percent of Adults in Households



Source: Findings from the 2003 Washington State Needs Assessment Household Survey: Substance Use, Substance Use Disorders, and Need for Treatment in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

* Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.

Washington State Tobacco Control Efforts are Resulting in Lower Smoking Prevalence Among Adults.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Cigarette smoking in the United States causes serious illnesses among an estimated 8.6 million Americans annually, with \$157 billion in health-related economic costs.¹ Tobacco use causes approximately 440,000 deaths each year, and since the release of the Surgeon General's report on smoking and health in 1964, more than ten million Americans have died from smoking-related diseases, including heart disease, lung cancer, emphysema, and other respiratory diseases.²

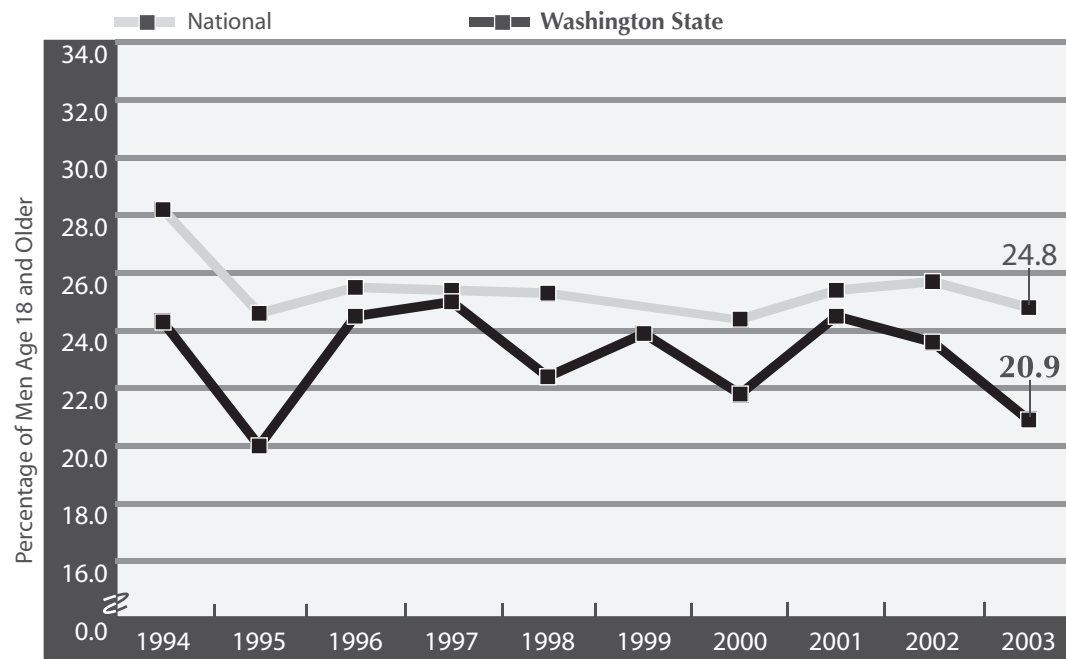
Smoking rates in Washington State appear to be on the decline. Studies indicate that the more funds that states spend on comprehensive tobacco-control programs, the greater the reduction in smoking.³ Smoking rates among 18-34 year olds in the United States (28.5%) and Washington (26.0%) are still at or close to their highest points in a decade, and indicate the need for greater effort.

¹ Centers for Disease Control and Prevention. "Cigarette Smoking-Attributable Morbidity—United States, 2000," *Morbidity and Mortality Weekly Report* 2003 (52); "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs—United States, 1995-1999," *Morbidity and Mortality Weekly Report* 2002 (51).

² Centers for Disease Control and Prevention. "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs—United States, 1995-1999," *Morbidity and Mortality Weekly Report* 2002 (51); U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: 2000.

³ Centers for Disease Control and Prevention. "State-Specific Prevalence of Current Cigarette Smoking Among Adults—United States, 2003," *Morbidity and Mortality Weekly Report* 2004 (53).

Smoking Prevalence Among Men in Washington State is Declining.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Smoking is closely associated with heart disease, cancer, emphysema, and other respiratory diseases. Since the release of the first Surgeon General's report on smoking and health in 1964, more than ten million Americans have died from smoking-related diseases.¹

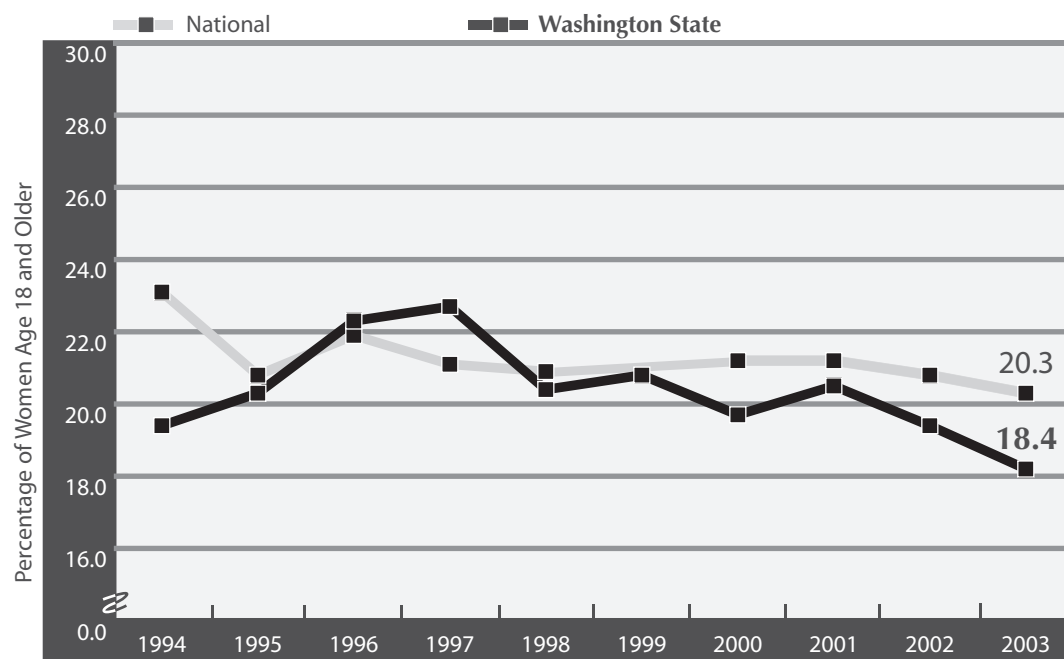
This graph indicates that smoking prevalence among Washington men is lower than men nationally, is declining, and is at its lowest point since 1995. In 2002, some 52.7% of Washington residents who smoked daily tried to quit.² The Division of Alcohol and Substance Abuse is engaged in a new initiative to integrate tobacco cessation into substance abuse treatment activities.

¹ U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: 2000.

² Centers for Disease Control and Prevention. "State-Specific Prevalence of Current Cigarette Smoking Among Adults—United States, 2002," *Morbidity and Mortality Weekly Report* 2004 (52).



Smoking Prevalence Among Women in Washington State is at Its Lowest Point in a Decade.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Besides being linked with heart disease, cancer, emphysema, and other respiratory diseases¹, evidence is accumulating that maternal tobacco use is associated with mental retardation and birth defects such as oral clefts², and with Sudden Infant Death Syndrome.³ More than ten million Americans have died from smoking-related diseases since the Surgeon General released the first report on smoking and health in 1964.⁴

This graph indicates that smoking prevalence among Washington women is lower than among women nationally, and is declining. The Division of Alcohol and Substance Abuse is engaged in a new initiative to integrate tobacco cessation into substance abuse treatment activities.

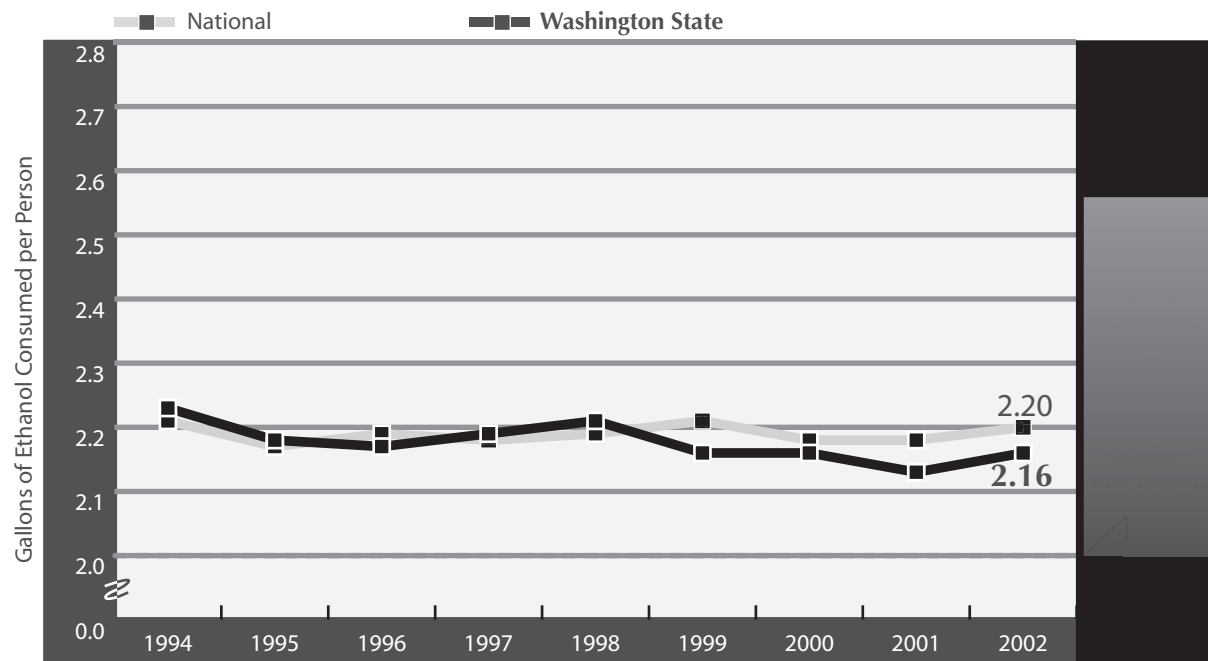
¹ U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: 2000.

² U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 27-3. Washington, DC: 2000.

³ Klonoff-Cohen, H. et al. "Effect of Passive Smoking and Tobacco Exposure Through Breast Milk on Sudden Infant Death Syndrome," *Journal of the American Medical Association*, March 8, 1995.

⁴ *Reducing Tobacco Use*, op. cit.

Per Capita Alcohol Consumption in Washington State is Similar to That of the Rest of the Nation.

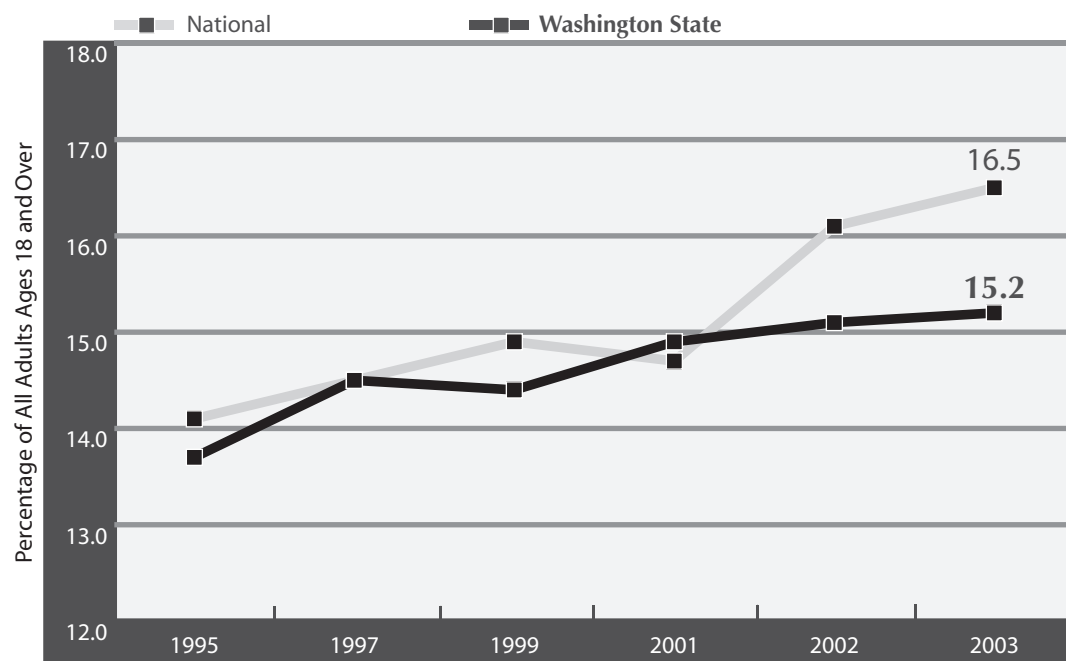


Source: National Institute on Alcohol Abuse and Alcoholism, *Surveillance Report #66: Apparent Per Capita Alcohol Consumption: National, State, and Regional Trends, 1977-2002*.

State and national per capita consumption of alcohol (for all persons over age 14) has remained constant over the past seven years. Per capita consumption is slowly approaching the *Healthy People 2010* target objective. However, in 2004, almost one in five Washington 10th graders reported binge drinking in the past 30 days, and chronic drinking rates among adults are at their highest point in a decade.



Adult Binge Drinking is on the Rise Both Nationally and in Washington State.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

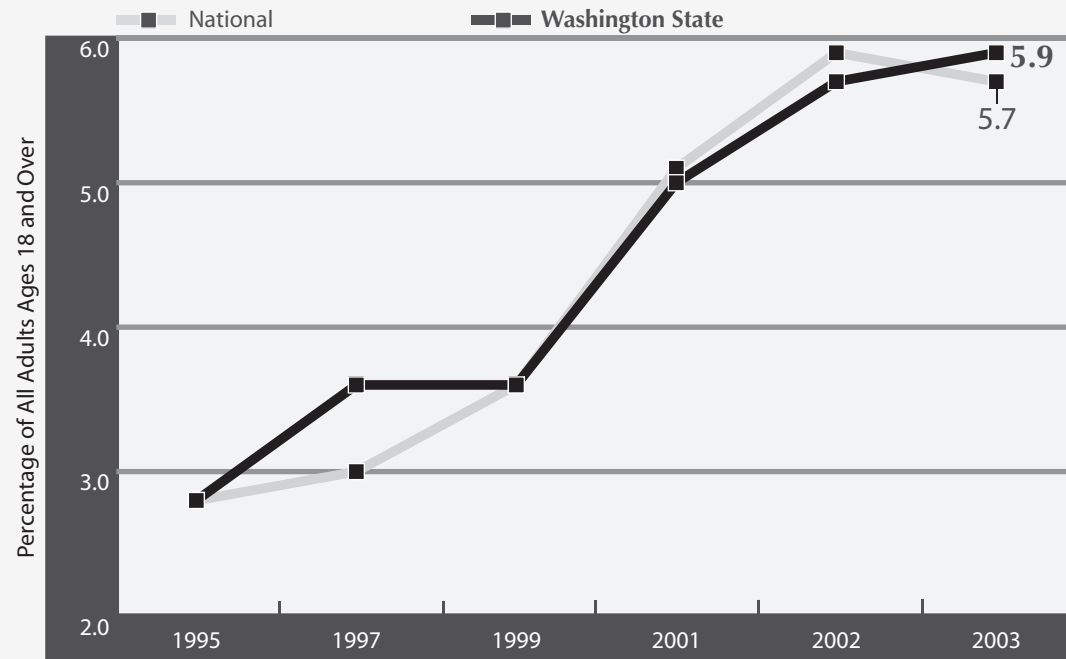
Binge drinking (defining as having five or more alcoholic drinks at one occasion, one or more times in the past month) is a particularly dangerous form of alcohol consumption, and is associated with traffic fatalities, accidents, drownings, emergency department admissions, and alcoholism. Binge drinking rates among college students (44% in 2001) are more than twice the rate for all adults¹, and is associated with increased incidence of unplanned and unprotected sex, alcohol-related sexual assaults, and date rape.²

After falling substantially for the previous decade, binge drinking in Washington State has been rising since 1995.

¹ Wechsler, H. et al. "Trends in College Binge Drinking During a Period of Increased Prevention Efforts: Findings from Four Harvard School of Public Health Study Surveys, 1993-2001," *Journal of American College Health* 50(5), 2002.

² Taskforce on College Drinking, National Advisory Council on Alcohol Abuse and Alcoholism. *A Call to Action: Changing the Culture of Drinking at U.S. Colleges*. Bethesda, MD: U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism, 2002.

Chronic Drinking Rates among Washington State Adults are Almost Double What They were in 1995.



Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Chronic drinking (defined as having had an average of two or more drinks per day per month) is associated with alcohol-related problems, including chronic liver disease and cirrhosis, certain forms of cancer, high blood pressure, heart rhythm irregularities, heart muscle disorders, and stroke.¹ It may also lead to alcohol dependency.

Both chronic drinking and binge drinking rates have risen significantly in the past decade, even as per capita alcohol consumption has remained steady. It is likely that problem drinkers make up a higher proportion of the alcohol-using population.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-4. Washington, DC: 2000.

The Problem: Substance Abuse Prevalence & Trends

AREAS OF
SUBSTANCE
ABUSE
IMPACT

Birth Defects/
Complications

Accident
Risks

Health
Consequences

Infectious
Diseases

Crime

Violence

Family
Distress

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

**Birth Defects/
Complications**

**Accident
Risks**

**Health
Consequences**

**Infectious
Diseases**

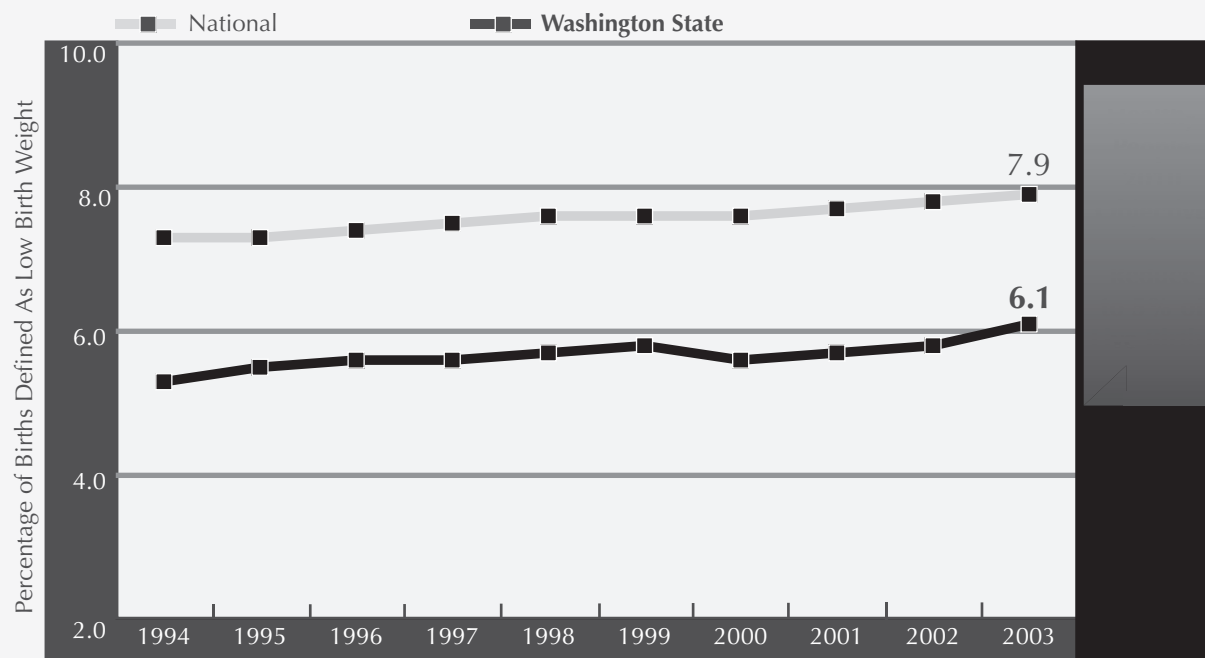
Crime

Violence

**Family
Distress**



The Rate of Low Birth Weight Births Has Been Rising Both in Washington State and Nationally



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Smoking is associated with 20-30% of all low birth weight (LBW) births, as well as being the risk factor most closely associated with neonatal deaths.¹

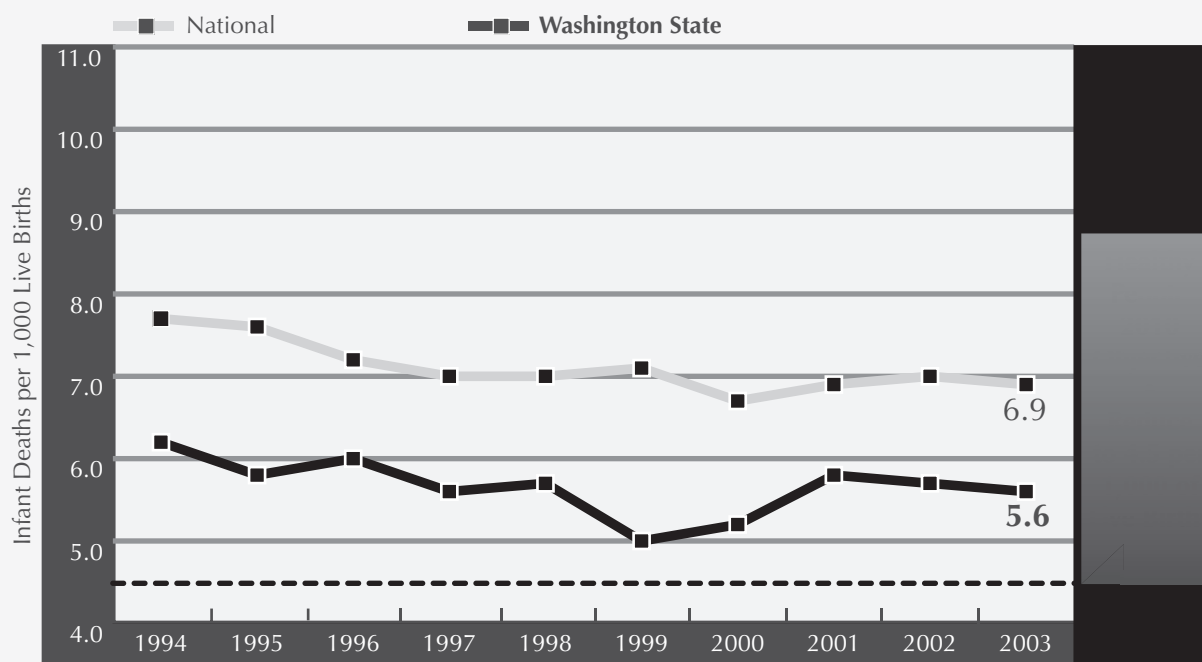
LBW infants are newborns weighing less than 2,500 grams (5 pounds, 8 ounces) and include those born prematurely and those whose intrauterine growth is retarded. LBW is associated with long-term disabilities, including cerebral palsy, autism, mental retardation, hearing impairments, and other developmental problems.² Two Washington studies reported fewer LBW births among substance-abusing women who received chemical dependency treatment during pregnancy.³

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4; 16-34. Washington, DC, 2000.

² Ibid.

³ Krohn, M. "Preliminary Findings for MOMS Project", *Focus*, 1993. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Shrager, L., Kenny F., and Cawthon, L. *Substance Abuse Treatment for Female DASA Clients: Treatments, Birth Outcomes, and Demographic Profiles*. Olympia, WA: Washington State Department of Social and Health Services, Office of Research and Data Analysis, 1993.

Washington State Has a Lower Infant Death Rate than the Nation.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

There is a clear association between overall rates of alcohol use during pregnancy and infant death rates. Infant mortality rates for children born to mothers on Medicaid in Washington State and identified as substance abusers are more than twice as high as those for infants born to mothers on Medicaid not so identified.¹

Infant death rates represent the number of infants per thousand live births who die within their first year of life. Sudden Infant Death Syndrome (SIDS) accounts for nearly one-third of all infant deaths after the first month of life.² SIDS has been linked with passive smoking in the infant's environment and maternal smoking during the time period of breastfeeding.³

Washington State has had consistently lower infant death rates than the nation. Rates have been dropping for the past 15 years. Advances in medical technology, coupled with public education campaigns to ensure infants are put to sleep on their backs to lower SIDS risk, are primarily responsible for the downward trend. SIDS-related deaths in Washington State are now at their lowest point in a decade.

¹ First Steps Database, 1990-1997. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1999.

² U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-1. Washington, DC, 2000.

³ Klonoff-Cohen, H. et al. "Effect of Passive Smoking and Tobacco Exposure Through Breast Milk on Sudden Infant Death Syndrome," *Journal of the American Medical Association*, March 8, 1995.

The Problem: Substance Abuse Prevalence & Trends

AREAS OF
SUBSTANCE
ABUSE
IMPACT

Birth Defects/
Complications

Accident
Risks

Health
Consequences

Infectious
Diseases

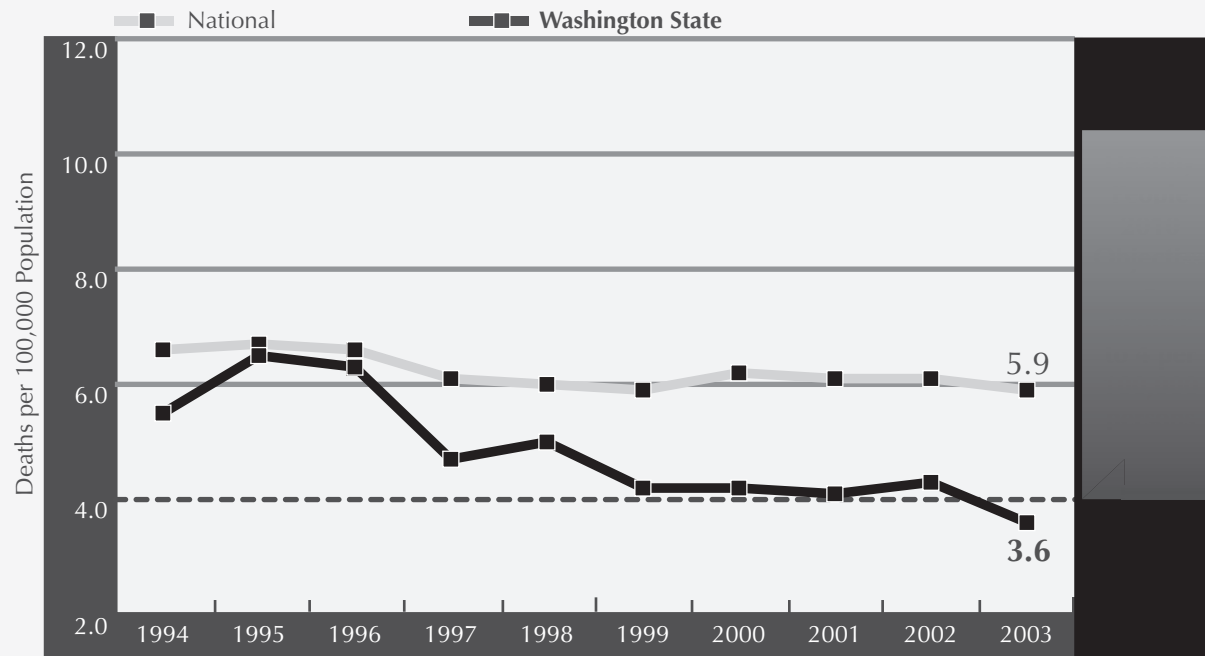
Crime

Violence

Family
Distress



Driving-Under-the-Influence (DUI) Statutes Implemented in 1999 in Washington State are Closely Associated with Lower Alcohol-Related Motor Vehicle Fatality Rates.



Source: National data from the National Center for Statistics & Analysis, National Highway Traffic Safety Administration. State data from the Fatality Analysis Reporting System, Washington Traffic Safety Commission.

Enhancements to Washington State's Driving-Under-the-Influence (DUI) statutes, including a lowering of the blood-alcohol concentration (BAC) for a DUI determination from .10% BAC to .08% BAC, went into effect in 1999. Since then, the rate of alcohol-related motor vehicle fatalities has dropped substantially. Similar changes have been demonstrated nationwide. The alcohol-related fatality rate for youth is higher than for adults, but nationwide has dropped more than 50% since 1982, mostly as a result of enforcement of minimum drinking age laws.¹

The number of alcohol-related fatalities in Washington State has declined from 296 in 1994 to 221 in 2003, representing a drop of 25.3%.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-14. Washington, DC. 2000.

The Death Rate from Alcohol-Related Motor Vehicle Crashes per 100 Million Miles Traveled Now Stands at an All-Time Low.



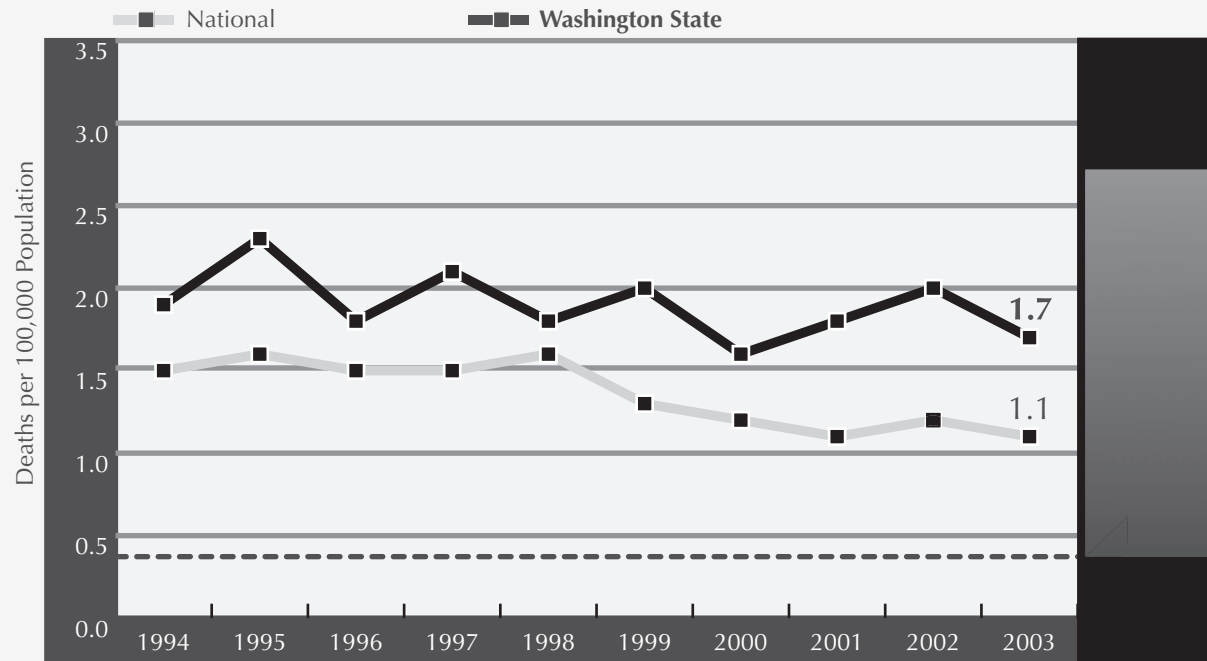
Source: National data from the National Center for Statistics & Analysis, National Highway Traffic Safety Administration. State data from the Fatality Analysis Reporting System, Washington Traffic Safety Commission.

In 2003, the motor vehicle fatality rate per 100,000 vehicle miles driven reached historic lows, both nationally and in Washington State. Lower fatalities are associated with enforcement of minimum drinking age and zero tolerance laws, and statutes setting lower blood alcohol concentration (BAC) standards for driving-under-the-influence.

Research indicates that the 5% of motorists who do not wear seatbelts account for over 50% of individuals killed in traffic crashes. Unbuckled motorists are more likely to engage in high-risk driving behaviors such as drunk driving and speeding, and are more likely to die when a crash occurs.¹



Washington State Has a Higher Rate of Deaths Due to Drowning than the Nation.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

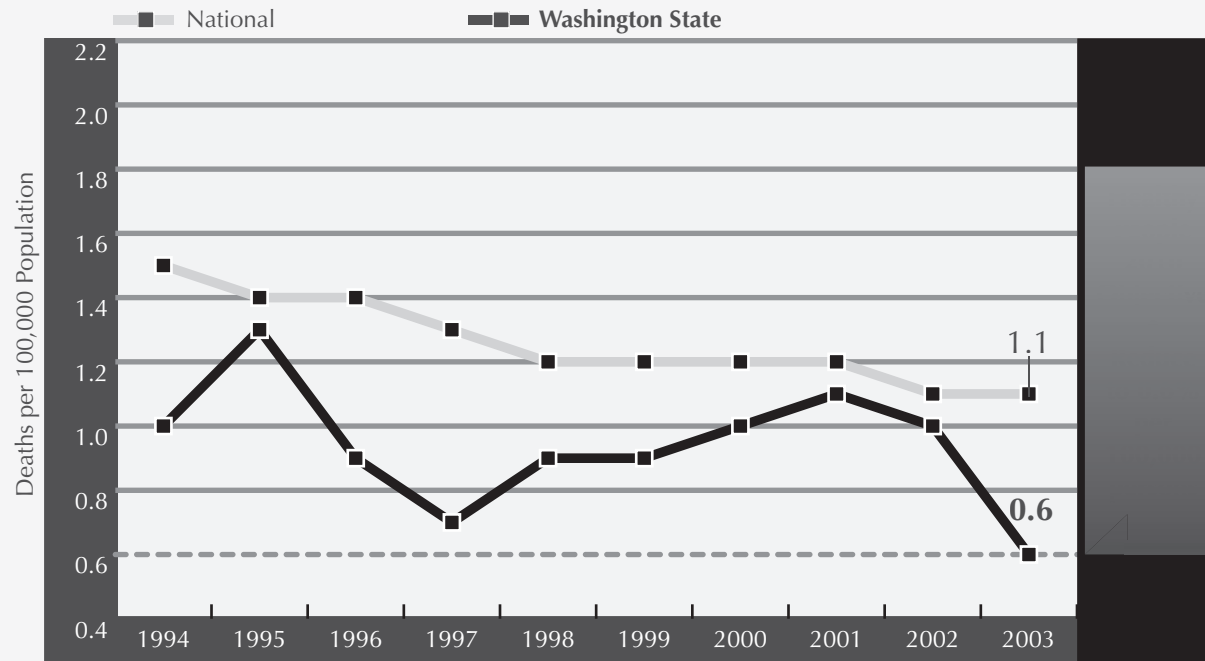
Alcohol is involved in approximately 50% of deaths associated with water recreation.¹

This graph indicates that the rate of drowning deaths in Washington State has been consistently higher than the national rate since 1993. There were 106 drowning deaths in Washington State in 2003, down from 119 in 2002. Nationally, drowning is the second leading cause of injury-related deaths for children and youth ages 1-19.²

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 15-40. Washington, DC: 2000.

² Ibid.

The Rate of Deaths Due to Residential Fires in Washington State Has Been Falling.



Source: National Data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

This graph indicates that the rate of deaths due to residential fires in Washington State has fallen in the past two years. There were 38 such deaths in 2003, the lowest number in more than a decade.

Fires are the second leading cause of unintentional injury death among children. Compared to the total population, children under age four have a fire death rate more than twice the national average. Two thirds of fire-related deaths and injuries among children under age five occur in homes without working smoke alarms.¹ Tobacco use is the leading cause of residential fire deaths.² Smoking causes an estimated 30% of U.S. fire deaths; costs related to fires have fallen in association with lower rates of smoking.³

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 15-35. Washington, DC: 2000.

² Centers for Disease Control and Prevention. *Fire Deaths and Injuries*. Atlanta, GA: 2000.

³ Leistikow, B., et al. "Fire Injuries, Disasters, and Costs from Cigarettes and Cigarette Lights: A Global Overview," *Preventive Medicine* 31:2, 2000.

The Problem: Substance Abuse Prevalence & Trends

AREAS OF
SUBSTANCE
ABUSE
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Birth Defects/
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Accident
Risks

Health
Consequences

Infectious
Diseases

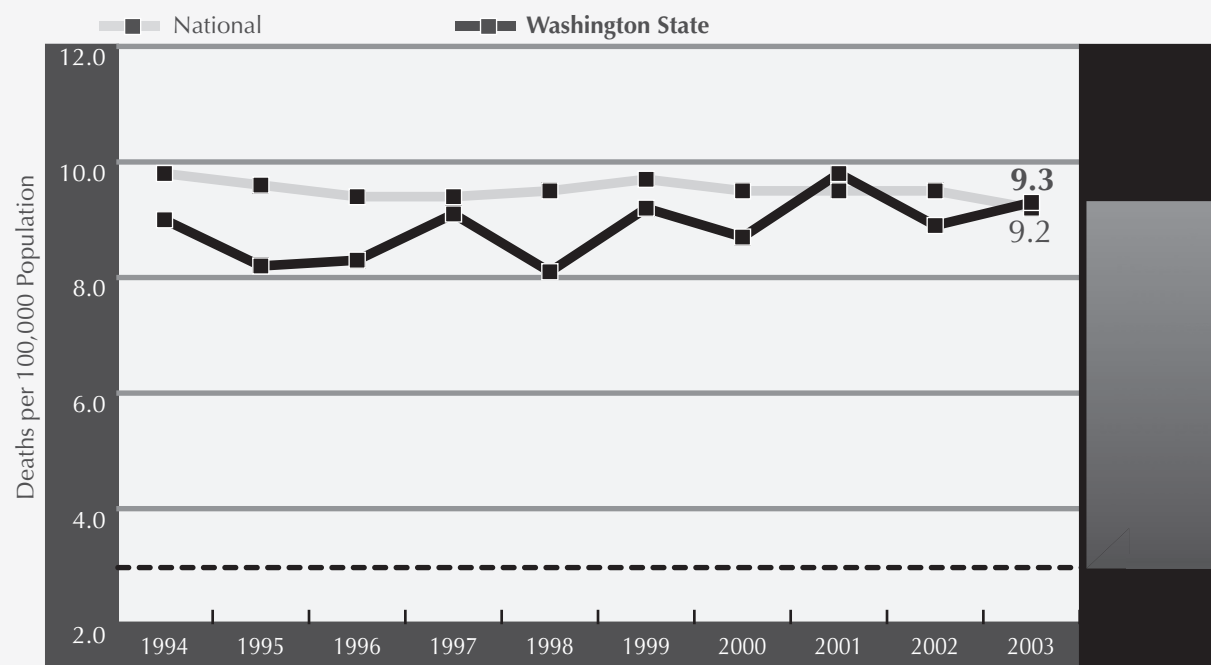
Crime

Violence

Family
Distress



Sustained Alcohol Consumption is the Leading Cause of Chronic Liver Disease and Cirrhosis Deaths.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

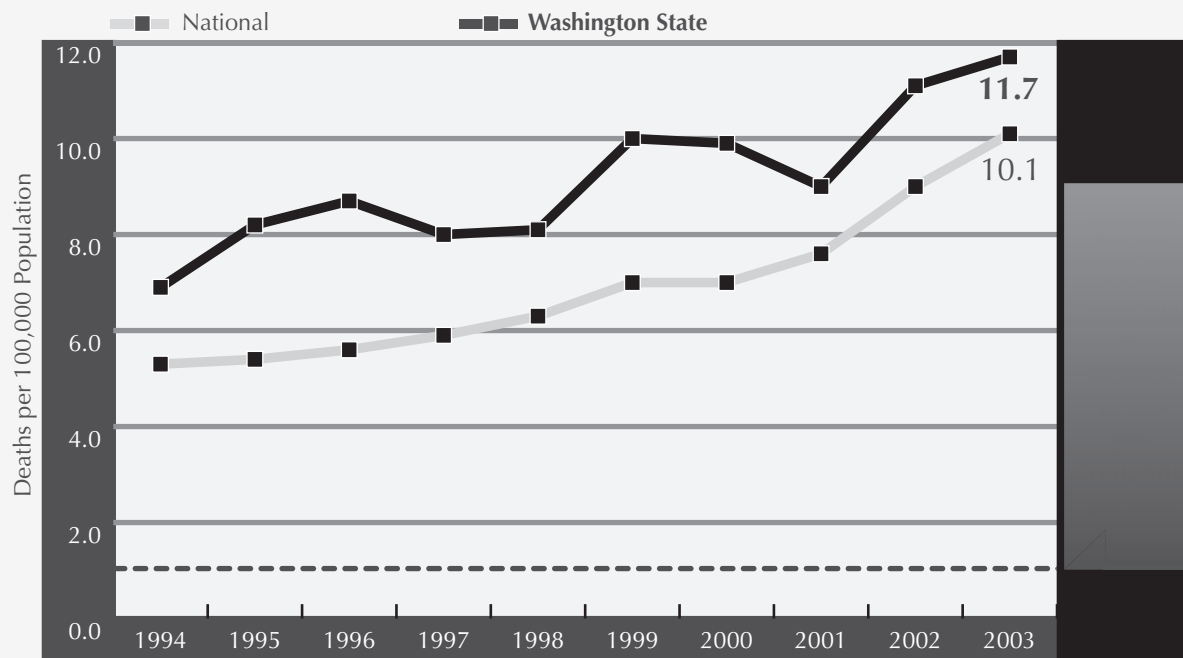
Cirrhosis occurs when healthy liver tissue is replaced with scarred tissue until the liver is unable to function effectively. Sustained heavy alcohol consumption is the leading cause of cirrhosis.¹ Cirrhosis is also associated with hepatitis C and, though less commonly in the United States, with hepatitis B², which are often transmitted during intravenous drug use. Once the liver is severely damaged, treatment is often limited to liver transplants.

Little progress has been made in Washington State or nationally in the past decade toward the *Healthy People 2010* target objective. There were 565 chronic liver disease and cirrhosis deaths in Washington State in 2003.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-16. Washington, DC: 2000.

² National Digestive Diseases Information Clearinghouse (NDDIC). *Cirrhosis of the Liver*. Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, 2003.

The Drug-Induced Death Rate in Washington State is Increasing.

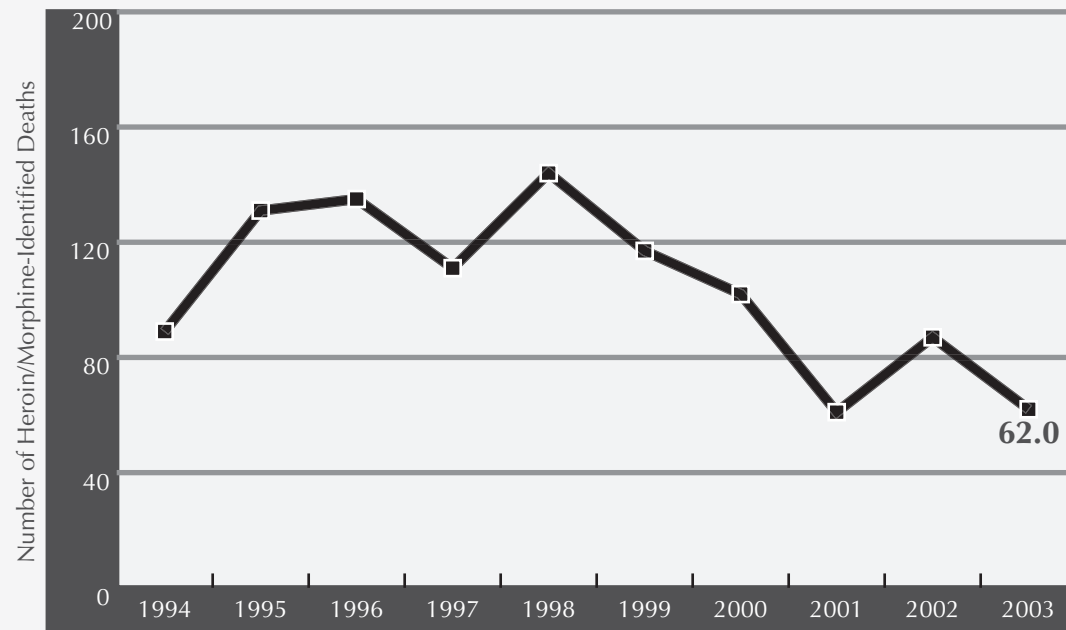


Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Drug-related death data provide a direct indication of the high human and social costs of drug use. Causes of death classified as drug-related include drug psychosis, drug dependence, suicide, and intentional and unintentional poisoning resulted from illicit drug use. Rising rates may be at least partially due to increases in prescription drug abuse-related deaths.

This graph indicates that Washington State continues to have a higher drug-induced death rate than the nation, with 736 such deaths in 2003.

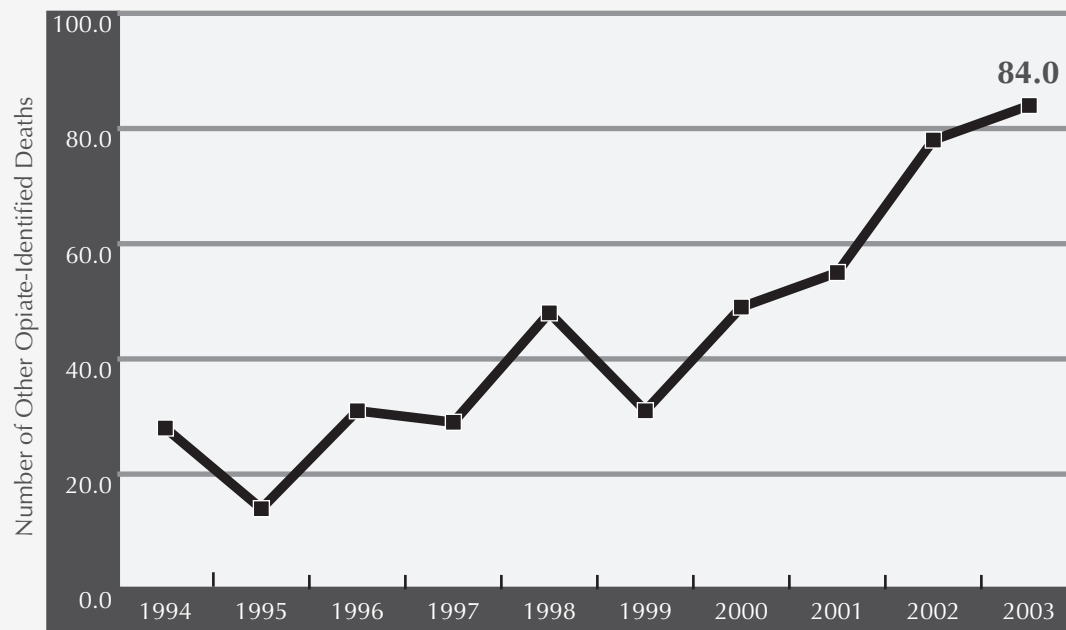
After Reaching a High in 1998, Rates of Heroin-Related Deaths in Seattle-King County are on the Decline.



Source: King County Medical Examiner.

This graph indicates that heroin/morphine-identified deaths in Seattle-King County have declined 57% since 1998. Much of the decline is likely due to public health measures adopted by city and county governments to address heroin addiction. King County authorized a 50% expansion in the number of opiate substitution treatment slots, and authorized a mobile methadone clinic. They have also provided preventive and limited substance abuse treatment services in the local criminal justice system, and expanded the availability of drug-free housing for individuals in recovery. The opening of three new methadone clinics in Snohomish County in the past two years will likely result in more slots being available in King County programs for residents.

The Number of Other Opiates* Identified in Drug-Caused Deaths in King County is Rising Rapidly.



Source: King County Medical Examiner.

The use of other opiates in pain management has risen substantially in recent years. As the population ages, and as medical science is better able to manage conditions which previously would have resulted in more rapid death, the use of pain management medications plays an important role in increasing quality of life. The Seattle office of the federal Drug Enforcement Administration reports that sales of prescription oxycodone to hospitals and pharmacies rose 359% between 1997-2003, and prescription methadone (non-opiate substitution treatment-related) rose 312%.¹

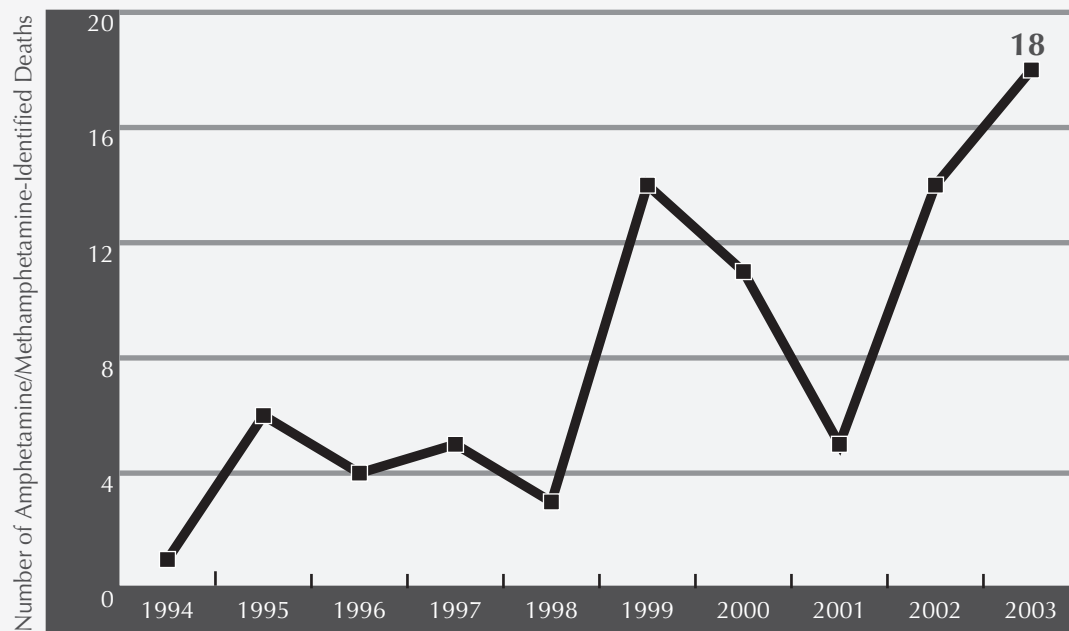
The expanded prescriptive use of other opiates, however, creates new opportunities for diversion and illicit use. There have been substantial increases in mentions of oxycodone and methadone among drug-related deaths over the past decade. OxyContin, illicit use of which has become epidemic in parts of the United States, is a time-release formulation of oxycodone.

**Defined as opiates other than heroin or morphine. These include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, and propoxyphene. There are more mentions than deaths because some individuals had multiple other opiates detected at time of death.*

¹ Banta-Green, C. et al. "Recent Drug Abuse Trends in the Seattle-King County Area, January 2005," *Proceedings of the Community Epidemiology Workgroup*, (draft) March 2005.



Methamphetamine-Related Deaths in Seattle-King County Have Risen in the Past Decade.*

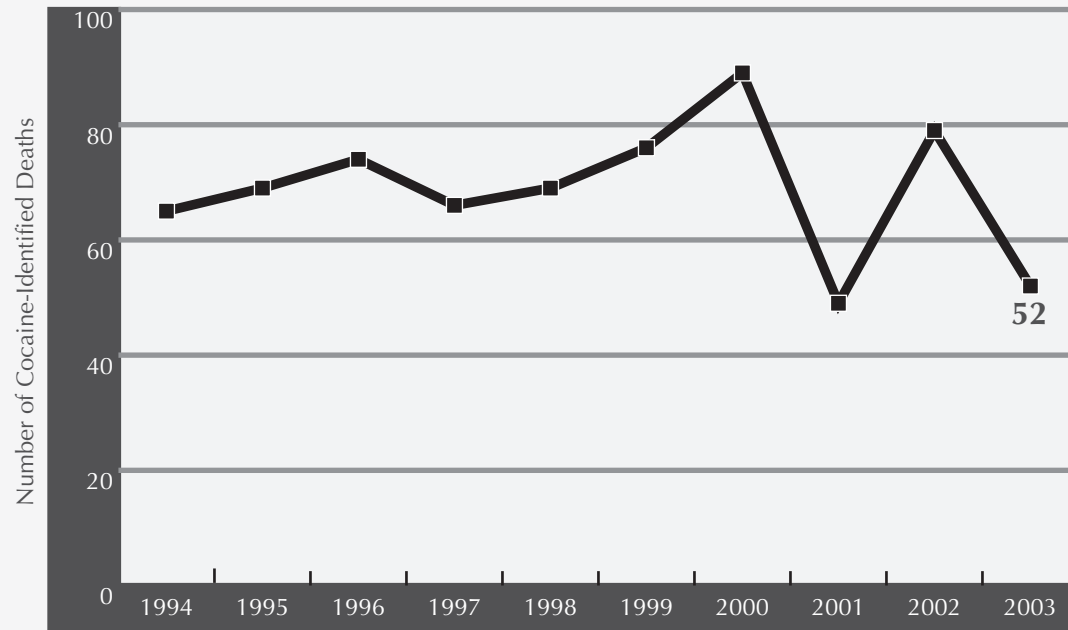


Source: King County Medical Examiner

The rise in methamphetamine-related deaths in Seattle-King County parallels the increase in reported methamphetamine laboratories and dump sites in the country, which grew from 7 in 1994 to a high of 271 in 2001. The number of treatment admissions among King County residents whose primary drug of abuse was methamphetamine rose from 416 in SFY 2000 to 632 in SFY 2004, representing a 52% increase.

**Includes other amphetamines.*

Cocaine-Related Deaths in Seattle-King County Remain High.



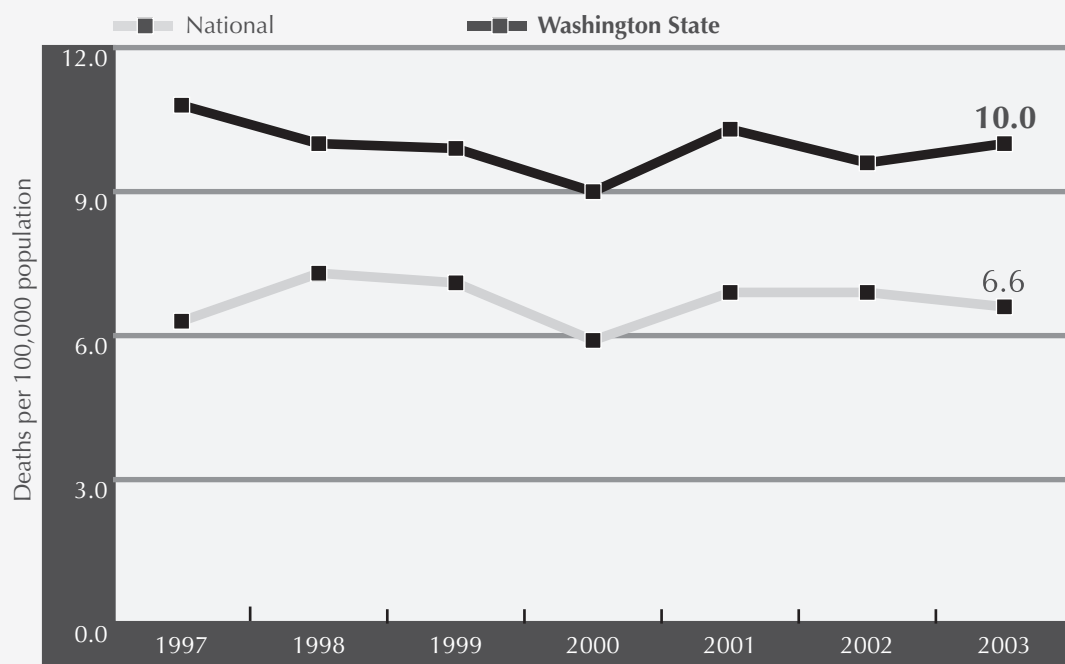
Source: King County Medical Examiner

Cocaine continues to be a major drug of abuse, with high levels of mortality and treatment admissions, especially among African-Americans. It is the drug most commonly named by King County adult residents calling the 24-Hour Alcohol/Drug Help-Line, and third most commonly named by youth.¹

¹ Banta-Green, C. et al. "Recent Drug Abuse Trends in the Seattle-King County Area," *Epidemiologic Trends in Drug Abuse*, January 2005.



Washington State Has a Higher Alcohol-Induced Death Rate than the Nation.



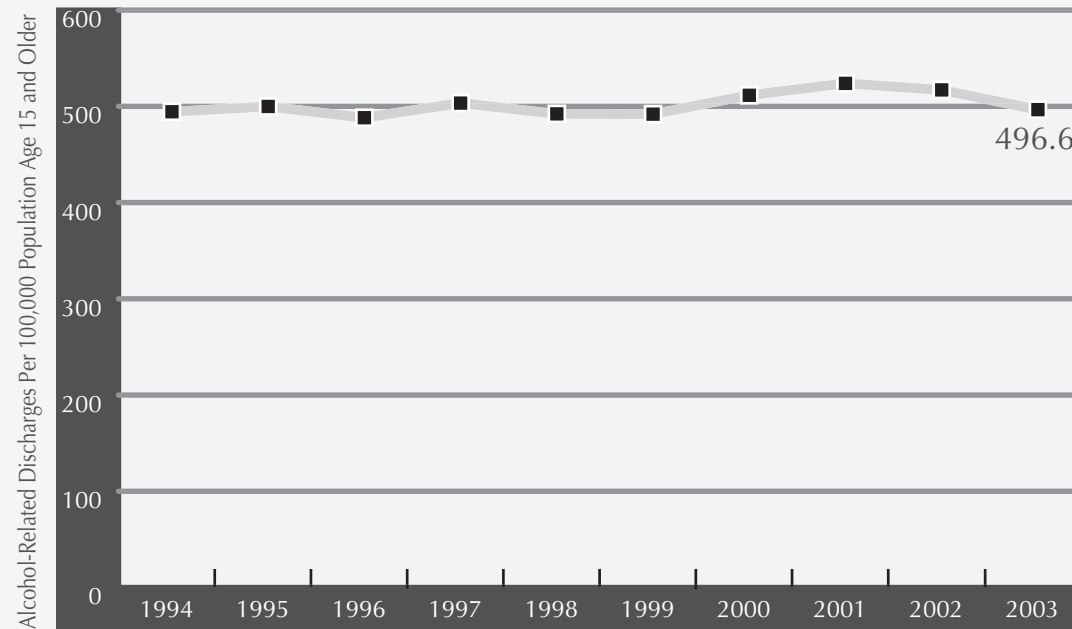
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Alcohol-related death data provide a direction indication of the high human and social costs of alcohol use. Long-term heavy drinking increases risks for high blood pressure, heart rhythm irregularities (arrhythmias) and heart muscle disorders (cardiomyopathy), and stroke. It increases risks for certain forms of cancer, especially esophagus, mouth, throat, and larynx; for cirrhosis and other liver disorders; and worsens outcomes for individuals with hepatitis C. It is also linked with death from traffic crashes, falls, fires, and drowning, and is associated with homicide, suicide, domestic violence, and child abuse.¹

This graph indicates that Washington State has had a consistently greater alcohol-induced death rate than the nation. In 2003, it was 52% higher. There were 619 alcohol-induced deaths in Washington State in 2003.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-4. Washington, DC: 2000.

The Rate of Alcohol-Related Diagnoses in Acute Care Hospital Discharges in Washington State is Unchanged Over the Past Decade.



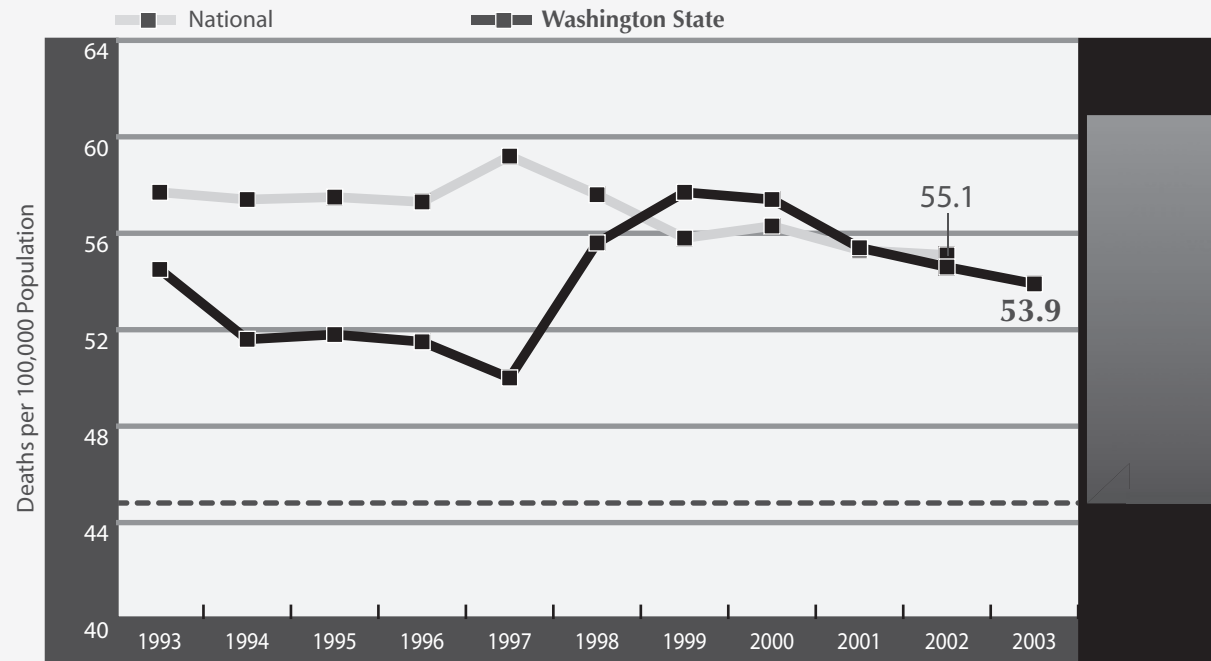
Source: Comprehensive Hospital Abstract Reporting System (CHARS), Washington State Department of Health.

Patients with alcohol-related diagnoses are discharged from acute care hospitals having been diagnosed with primary alcohol-related conditions such as alcohol psychoses, alcohol dependence syndrome, nondependent abuse of alcohol, and chronic liver disease and cirrhosis. These diagnoses do not include alcohol-related trauma such as injuries from motor vehicle crashes, or discharges associated with maternity stays. There were 24,217 patients with alcohol-related diagnoses discharged from Washington State acute care hospitals in 2003.

With a grant from the federal Substance Abuse Mental Health Services Administration, the Division of Alcohol and Substance Abuse has initiated a program in six Washington hospitals, whereby individuals affected by alcohol or other drugs who visit emergency departments are receiving brief interventions related to their substance abuse, and referred to treatment when appropriate.



The Lung Cancer Death Rate in Washington State is Similar to That of the Nation.



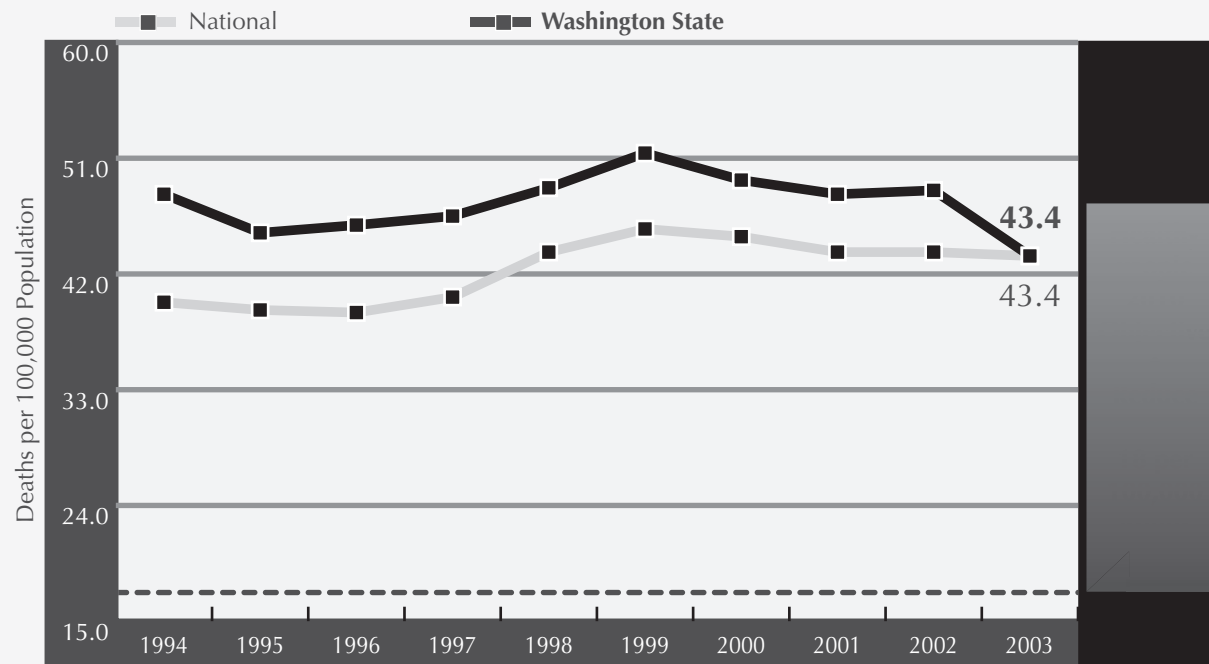
Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

The vast majority of lung cancer cases are attributable to cigarette smoking, accounting for 68-78% of lung cancer deaths among females, and 88-91% of deaths among males. Smoking cessation decreases the risk of lung cancer to 30-50% of that of continuing smokers after ten years of abstinence.¹

This graph indicates that, while lower for most of the past decade, lung cancer death rates in Washington State are now similar to those of the nation. Lung cancer is the most common category of cancer mortality in the U.S.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 3-12. Washington, DC: 2000.

The Death Rate in Washington State from Chronic Lower Respiratory Disease is Now Similar to the Nation's.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Chronic lower respiratory disease (formerly known as chronic obstructive pulmonary disease) occurs most often in people over age 65. Between 80-90% of cases are attributable to cigarette smoking.¹

This graph indicates that the mortality rate from chronic lower respiratory disease in Washington State is the same as it is nationally. Chronic lower respiratory disease includes chronic bronchitis and emphysema, both of which are characterized by irreversible airflow obstruction. Both conditions often exist together.² There is clear evidence that smoking cessation relieves symptoms and slows the progression of chronic lower respiratory disease, reduces the risk of lung and other cancers, and increases life expectancy.³

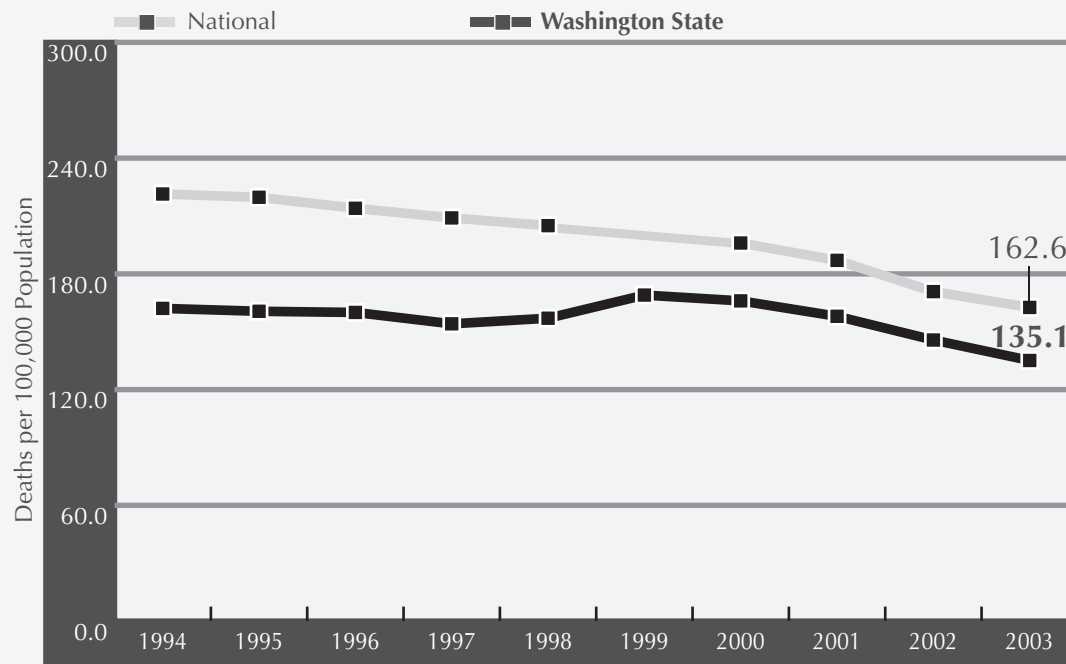
¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 24-8. Washington, DC: 2000.

² *Ibid.*

³ Rigotti, N. "Treatment of Tobacco Use and Dependence," *New England Journal of Medicine* 346(7), February 14, 2002.



The Ischemic Heart Disease Death Rate in Washington State is Lower than the National Rate.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Heart disease is the leading cause of mortality in the United States, and ischemic heart disease (heart attacks) accounts for the largest portion of heart disease deaths. About 12 million Americans have ischemic heart disease. Prevention strategies included reducing blood cholesterol, high blood pressure, obesity and excessive weight gain, and cigarette smoking, as well as increasing amounts of physical activity.¹ In 2000, obesity and physical activity caused 400,000 U.S. deaths, 16% of the total, and is now considered the nation's second leading killer, after tobacco use.² Quitting smoking reduces risks of heart disease and heart attacks regardless of age of cessation.³

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 12-6. Washington, DC: 2000.

² Mokdad, A. et al. "Actual Causes of Death in the United States, 2000," *Journal of the American Medical Association* 291(10), March 10, 2004.

³ Taylor, D. et al. "Benefits of Smoking Cessation for Longevity," *American Journal of Public Health* 92(6), 2002.

The Problem: Substance Abuse Prevalence & Trends

AREAS OF
SUBSTANCE
ABUSE
IMPACT

Birth Defects/
Complications

Accident
Risks

Health
Consequences

Infectious
Diseases

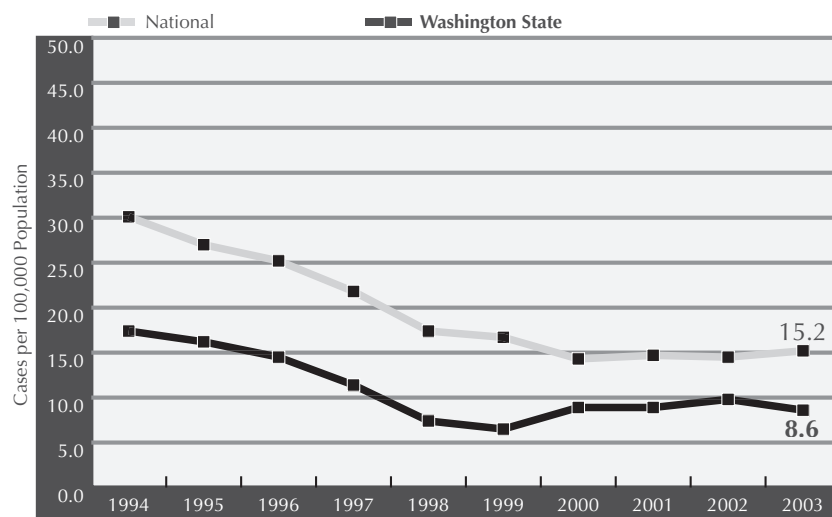
Crime

Violence

Family
Distress



The Reported AIDS Case Rate in Washington State is Lower than the Nation's.*



Source: National and state data from the Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report* Vol. 15, December 2004.

From January 1982 through February 2005, 10,978 AIDS (Acquired Immune Deficiency Syndrome) cases were reported in Washington State, and there were 5,914 deaths from the disease. As of February 2005, there were 5,064 Washington residents living with AIDS. Some 17% of AIDS cases in Washington State were traceable to possible exposure from injection drug use, substantially lower than the percentage of cases attributed to injection drug use nationally.¹ Studies have shown that cities that implemented needle exchange programs early in the AIDS epidemic – such as Seattle and Tacoma – have much lower infections rates among injection drug users (IDUs).

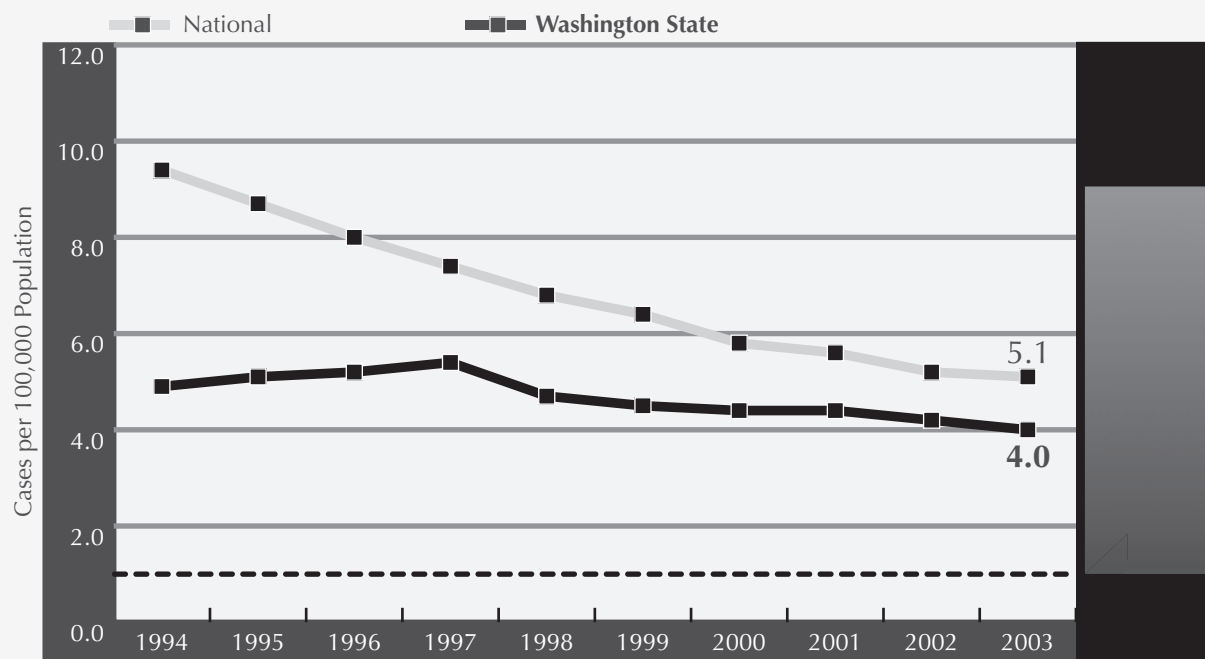
This graph indicates that the reported AIDS case rate in Washington is consistently lower than the nation's. Since 1994, the AIDS case rate has generally been in decline, reflecting the effectiveness of new treatments in preventing HIV (human immunodeficiency virus) infection from progressing to AIDS. However, there is concern about an increase in behaviors that put individuals at risk for HIV transmission. Nationally, well over half of individuals diagnosed with AIDS live longer than seven years after the diagnosis.²

* Case counts are provisional; reporting is considered incomplete for several years.

¹ Office of HIV Prevention and Education. Washington State Department of Health, 2005.

² Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* Vol. 14, October 2003.

The Case Rate for New Tuberculosis Cases is at Its Lowest Point in Recorded Washington State History.



Source: National data from the Division of Tuberculosis Elimination, Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention. State data from Assessment Unit – Infectious Disease and Reproductive Health, Washington State Department of Health.

Multiple risk factors, including poverty, homelessness, substance abuse, gaps in health care infrastructure, and the human immunodeficiency virus (HIV) epidemic, are associated with new tuberculosis cases. Ensuring that patients with active tuberculosis infection complete curative therapy early is essential to curbing the disease's spread. Washington State has adopted treatment provider regulations to screen all chemical dependency patients to help prevent and control the spread of the disease.

This graph indicates that Washington State has had a consistently lower tuberculosis rate than the nation. After a national and state resurgence in the early 1990s, the tuberculosis epidemic has receded, and is now at its lowest point in Washington State's recorded history.



The Rate of Acute Hepatitis B in Washington State Has Declined in the Past Decade.



National data from the Epidemiology Program Office, National Notifiable Disease Surveillance System, Centers for Disease Control and Prevention. State data from Washington State Department of Health, *Annual Communicable Disease Report – 2002*.

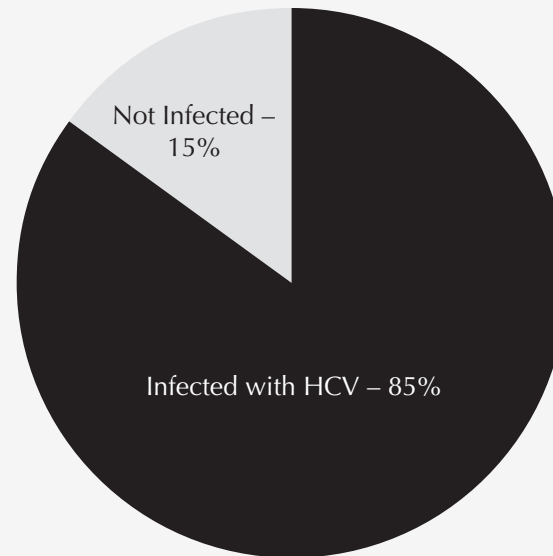
Injection drug uses is a major risk factor for hepatitis B infection. Most cases occur in young adult risk groups, including persons with a history of multiple sex partners, men who have sex with men, injection drug users, incarcerated persons, and household and sex contacts of infected partners. It may also be transmitted perinatally.¹

This graph indicates that the rate of acute hepatitis B cases in Washington State has declined over the past decade. Hepatitis B is a serious disease that attacks the liver, and chronic hepatitis B infection, which may be carried without sign of infection, is associated with cirrhosis, liver cancer, and liver failure. The greatest decline in infections over the past decade has been in children and adolescents, and associated with routine childhood vaccination.² Nationally, there has been a 64% decline in acute hepatitis B cases since 1990.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 14-15. Washington, DC: 2000.

² Centers for Disease Control and Prevention. "Incidence of Acute Hepatitis B – United States, 1990-2002," *Morbidity and Mortality Weekly Report* 52(51), January 2, 2004.

Some 85% of Injection Drug Users in King County are Infected with Hepatitis C Virus (HCV).



Source: Community Epidemiology Work Group, National Institute on Drug Abuse, National Institutes of Health, *Recent Drug Trends in the Seattle-King County Area*, December 2003.

Of the 15,000-18,000 injection drug users (IDUs) in Seattle-King County, 85% are infected with the hepatitis C virus (HCV). Recent incidence studies indicate that 21% of non-infected Seattle-area IDUs acquire HCV each year.¹

HCV is the most common chronic bloodborne viral infection in the United States, affecting an estimated 2.7 million people in the U.S., and causes an estimated 8,000-10,000 deaths each year from cirrhosis and liver cancer.² As many as 100,000 people in Washington State are believed to be infected, with 250 deaths annually.³ It is the leading reason for liver transplantation in the U.S. Even moderate alcohol use is known to exacerbate liver injury resulting from HCV.

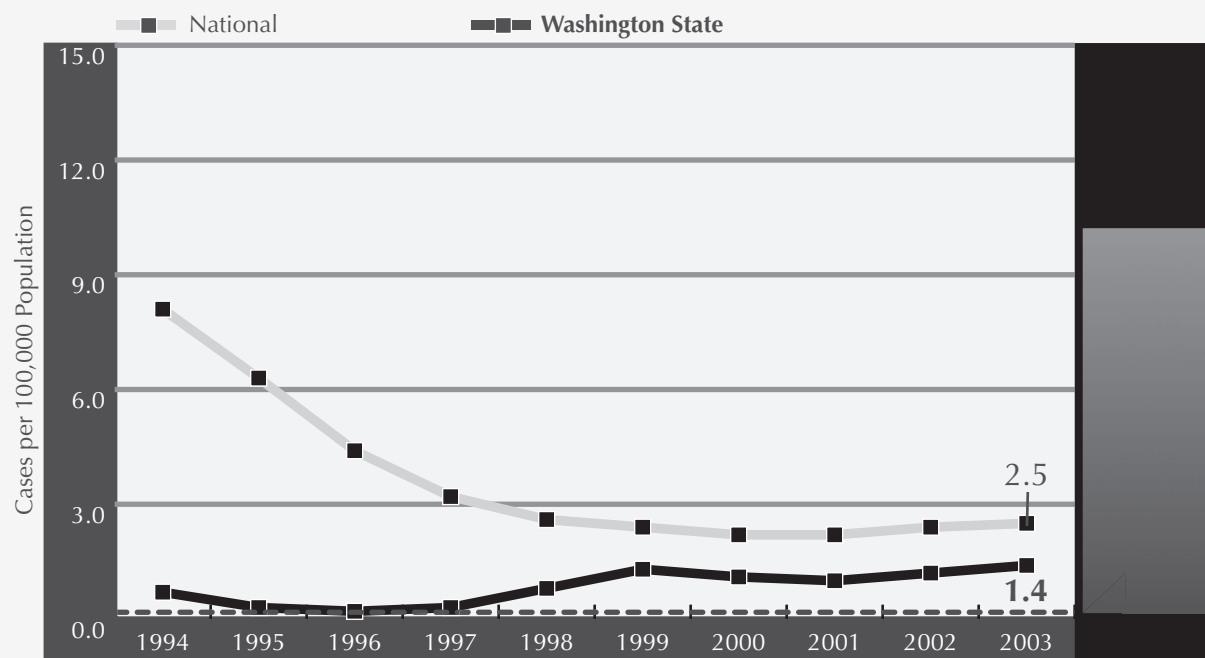
¹ Banta-Green, C. et al. "Recent Trends in the Seattle-King County Area, December 2003," *Proceedings of the Community Epidemiology Work Group* Vol. II, December 2003.

² National Center for Infectious Diseases. *Viral Hepatitis C Fact Sheet*. Atlanta: GA: Centers for Disease Control and Prevention, 2004.

³ Office of Epidemiology. "Notifiable Conditions: Hepatitis C (HCV)," Washington State Department of Health, October, 2002.



Washington State Continues to Experience a Significant Increase in the Rate of Primary and Secondary Syphilis.



Source: National data from the National Center for HIV, STD, and TB Prevention, Centers of Disease Control and Prevention. State data from Washington State Department of Health, *2003 Sexually Transmitted Disease Morbidity*.

The spread of sexually transmitted diseases (STDs), including syphilis, is often linked to the use of alcohol and other drugs. The introduction of new illicit substance use into a community often can substantially alter sexual behavior in high-risk sexual networks. Increases in the exchange of sex for drugs, increases in the number of anonymous sex partners, decreases in motivation to use barrier protection, lowered ability to negotiate safe sex practices, and declines in attempts to seek medical treatment can all fuel epidemic spread of STDs.¹

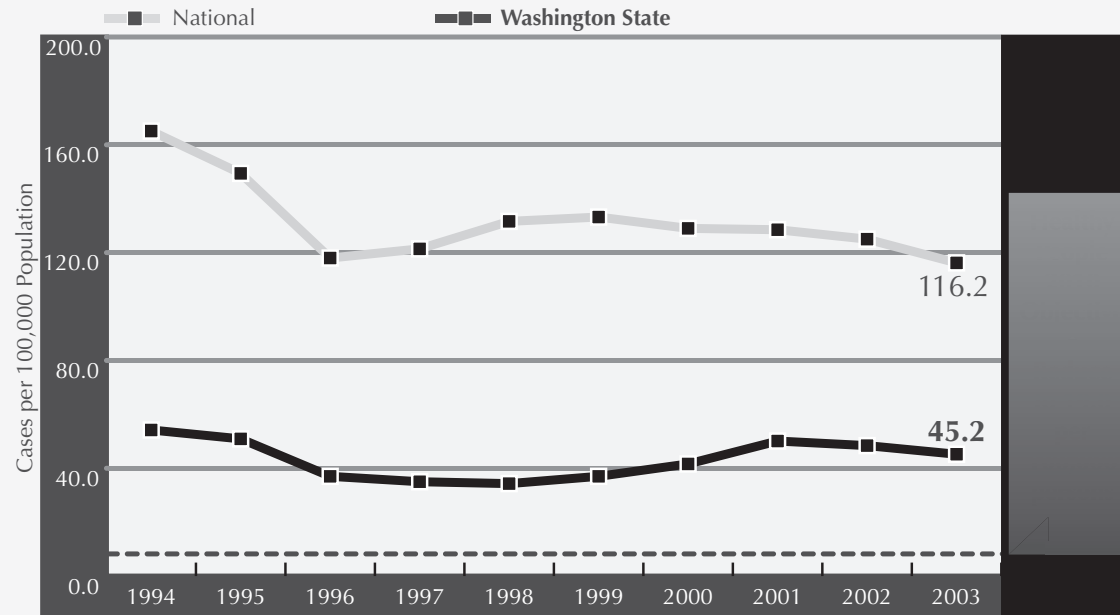
From a low of nine cases in 1996, Washington State has experienced a substantial increase in the number of primary and secondary (P&S) syphilis cases. There were 82 cases in 2003, 60 of them in King County (which only had a single case in 1996.) Transmission is strongly associated with men having sex with men², and may be associated with substance abuse, notably methamphetamine and inhaled nitrites.³ Counts of P&S syphilis cases may understate the problem, as cases are often diagnosed after they have gone beyond the primary and secondary stages and become latent.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 25-5. Washington, DC: 2000.

² STD/TB Services and Infectious Disease and Reproductive Health Assessment Unit, Washington State Department of Health. *Washington State 2003 Sexually Transmitted Disease Morbidity*. Olympia, WA: 2004.

³ Public Health, Seattle & King County. *Screening Guidelines for Men Who Have Sex with Men (MSM)*. Seattle, WA: 2001.

Gonorrhea Rates in Washington State Have Increased 41% Since 1998.



Source: National data from the National Center for HIV, STD, and TB Prevention, Centers of Disease Control and Prevention. State data from Washington State Department of Health, 2003 *Sexually Transmitted Disease Morbidity*.

The spread of sexually transmitted diseases (STDs), including gonorrhea, is often associated with substance abuse. Increases in the exchange of sex for drugs, increases in the number of anonymous sex partners, decreases in motivation to use barrier protection, lowered ability to negotiate safe sex practices, and declines in attempts to seek medical treatment can all fuel epidemic spread of STDs.¹

Washington State has experienced a serious resurgence in gonorrhea cases, from 1,948 cases in 1998 to 2,753 cases in 2003, representing a 41.3% increase. Much of this increase is associated with cases among men having sex with men in King County, among whom the rate of cases has more than quadrupled since 1994, and may be as much as nine times greater than for heterosexuals.²

Gonorrhea infections are a major cause of pelvic inflammatory disease, tubal infertility, ectopic pregnancy, and chronic pelvic pain. Epidemiologic studies indicate that gonococcal infections such as gonorrhea may facilitate HIV transmission.³

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 25-5. Washington, DC: 2000.

² STD/TB Services and Infectious Disease and Reproductive Health Assessment Unit, Washington State Department of Health. *Washington State 2003 Sexually Transmitted Disease Morbidity*. Olympia, WA: 2004.

³ Ibid.

The Problem: Substance Abuse Prevalence & Trends

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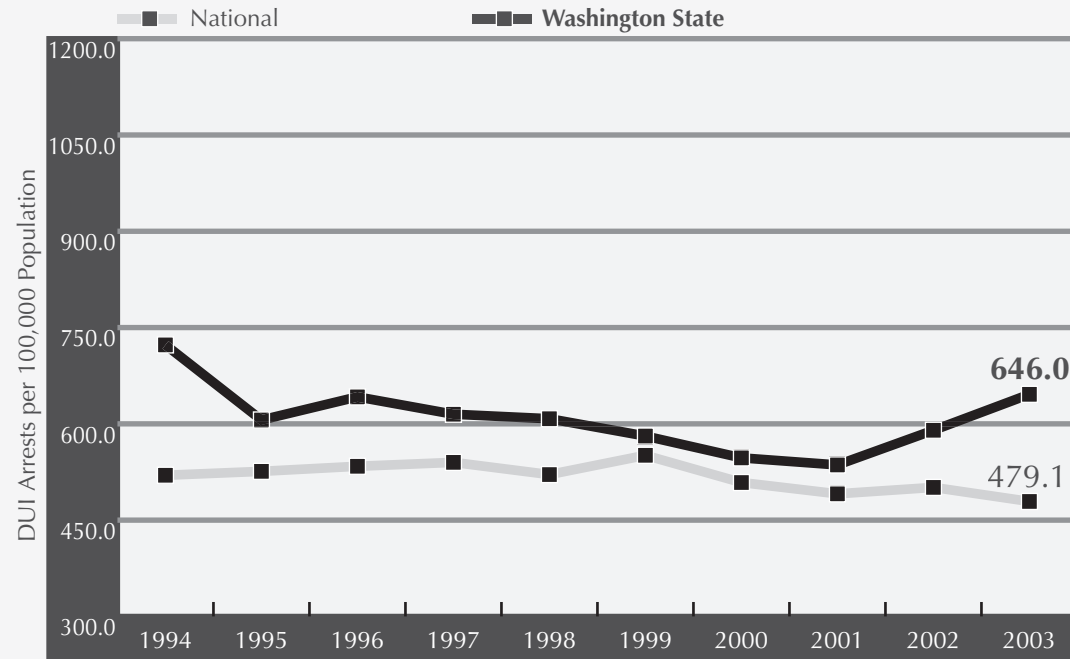
Crime

Violence

Family
Distress



Driving-Under-the-Influence Arrest Rates in Washington State Have Risen in the Past Several Years.



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States Annual Report*. State data from the Washington Association of Sheriffs & Police Chiefs.

Data for alcohol-related motor vehicle arrests may reflect a jurisdiction's laws, enforcement policy, financial resources, and officer discretion, in addition to the actual number of alcohol-related driving incidents. Washington State enacted new alcohol-related motor vehicle statutes in 1998, including lowering the blood alcohol concentration for proof of intoxication to .08, and zero tolerance for drivers under age 21. While the statutes have not resulted in significantly higher arrest rates, they have resulted in lower alcohol-related motor vehicle fatality rates.¹ In 2003, the number of motor vehicle fatalities in Washington State was at its lowest point since 1961.

¹ Salzburg, P. and Yamada, A. *Drunk Driving Trends in Washington State: Evaluation of the 1998 DUI Laws*. Olympia, WA: Traffic Research and Data Center, Washington Traffic Safety Commission, 2002.

Washington State Has a Lower Rate of Drug-Related Arrests than the Nation.

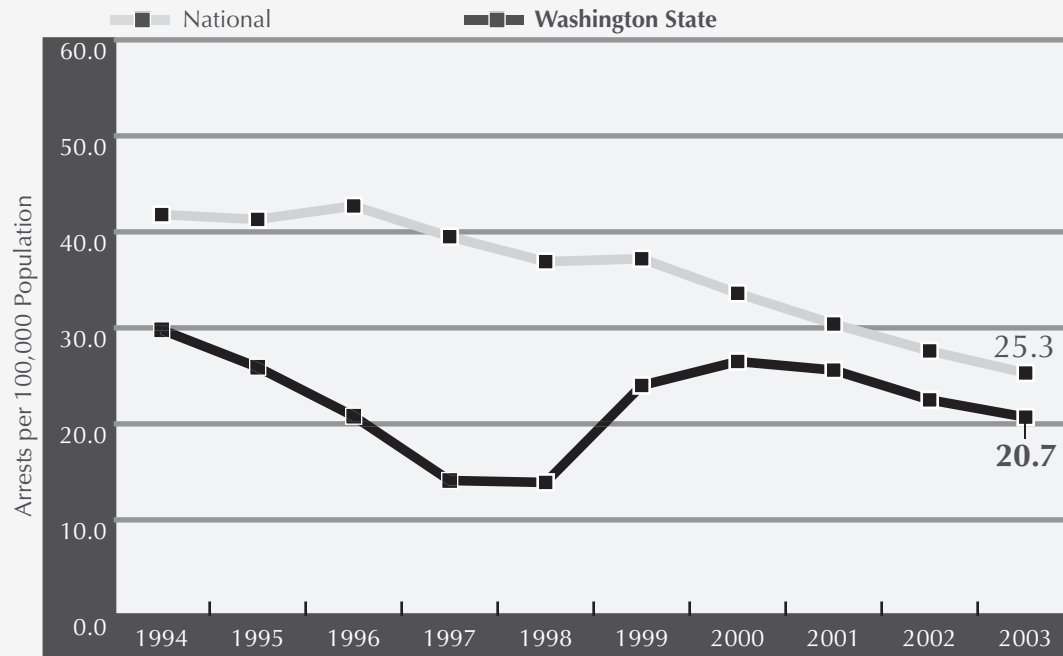


Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* Annual Report. State data from the Washington Association of Sheriffs & Police Chiefs.

Data for drug-related arrests may reflect a jurisdiction's laws, enforcement policy, financial resources, and officer discretion, in addition to the actual number of alcohol-related driving incidents. There were 23,358 adults and 3,140 youth arrested for drug violations in 2003. Many individuals now receive judicially supervised treatment in lieu of incarceration with funds provided under the Criminal Justice Treatment Account.



Arrest Rates in Washington State for Prostitution are Below the National Rate.



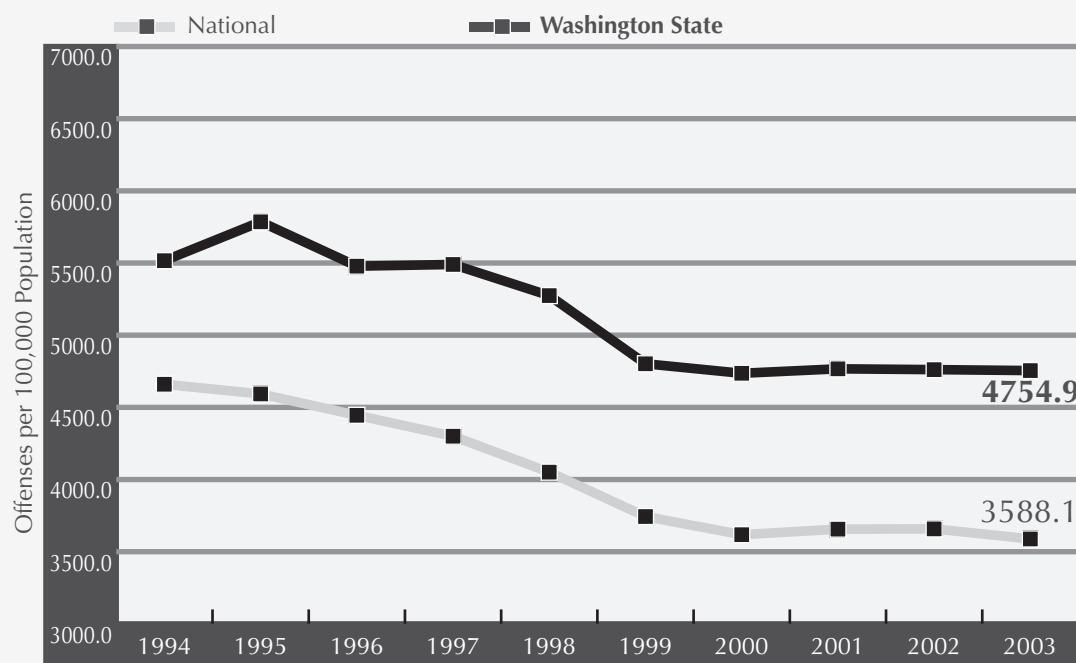
Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State* annual reports.

The Arrestee Drug Abuse Monitoring Program reported that 78.3% of those arrested for prostitution in Seattle in 1999 tested positive for illegal drugs, mostly for cocaine.¹ Prostitution is associated with the spread of HIV/AIDS and other sexually transmitted diseases.

This graph indicates that arrest rates for prostitution in Washington State are significantly lower than that of the nation. Of the 1,263 prostitution arrests in Washington State in 2003, 353 (representing 27.9% of the total) were male. It should be noted that arrest rates may be influenced by a jurisdiction's financial resources, enforcement policy, and officer discretion, as well as the actual level of criminal activity.

¹ Office of Justice Programs, National Institute of Justice. *Arrestee Drug Abuse Monitoring Program 1999 Annual Report*. Washington, DC: U.S. Department of Justice, 2000.

Washington State Has a Higher Property Crime Index than the Nation.



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington* annual reports.

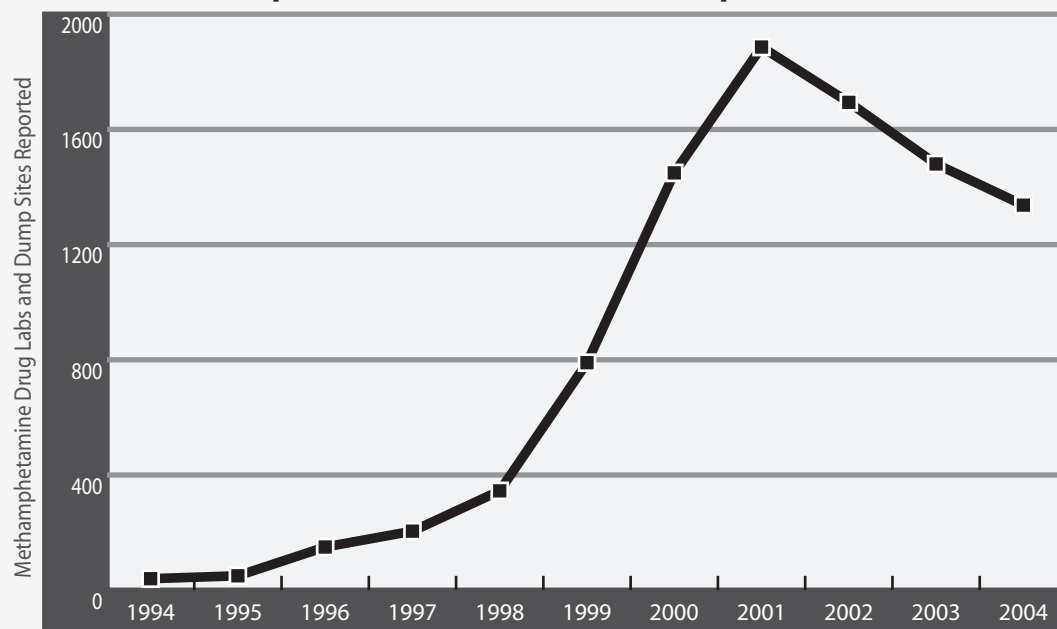
The Arrestee Drug Abuse Monitoring Program found that in 2000, 73.4% of males arrested for property offenses in King County, and 71.5% arrested for property offenses in Spokane County tested positive for illegal drugs.¹

This graph indicates that the Washington State property crime index is higher than the nation's, but is in a downward trend. The property crime index includes burglary, larceny-theft, motor vehicle theft, and arson. Distinct from arrest data, this index counts one offense for each victim who reports a property crime to the police, regardless of the number of offenders involved.



The Number of Reported Methamphetamine Laboratories and Dump Sites in Washington State Has Fallen Almost 30% Since 2001.

Number of Reported Meth Labs and Dump Sites



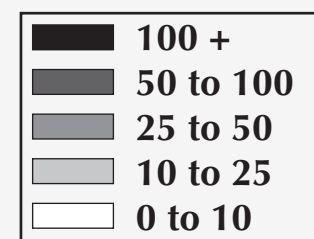
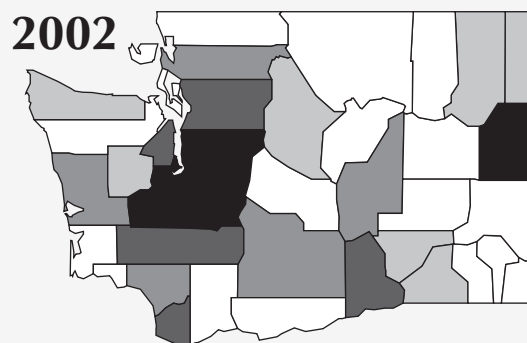
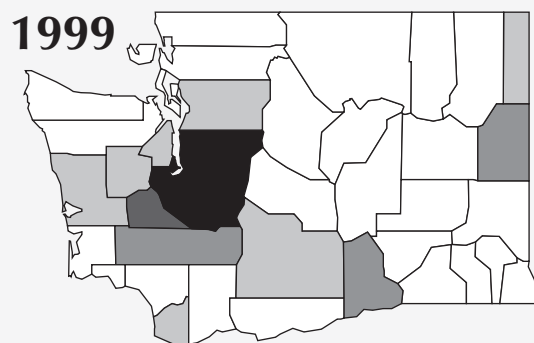
Source: Washington State Department of Ecology, 2005.

This graph indicates that after dramatic increases since 1994, the number of illegal methamphetamine (meth) laboratories and dump sites in Washington State continues to drop, and has fallen 29.3% since 2001. The largest number of reports in 2004 came from Pierce (541), King (199), Snohomish (101), Thurston (61), and Benton (57) Counties. The largest statistically significant percentage increase was in Skagit County (from 12 in 2003 to 31 in 2004); the largest declines were in Lewis (from 67 in 2003, to 30 in 2004) and Spokane Counties (from 91 in 2003, to 42 in 2004).

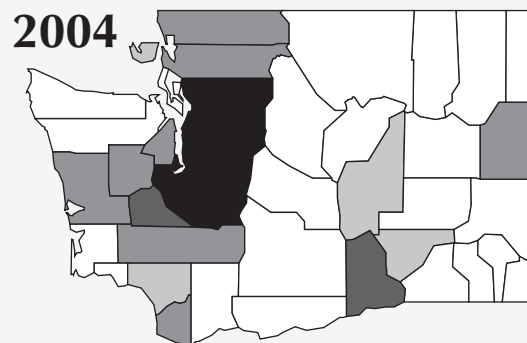
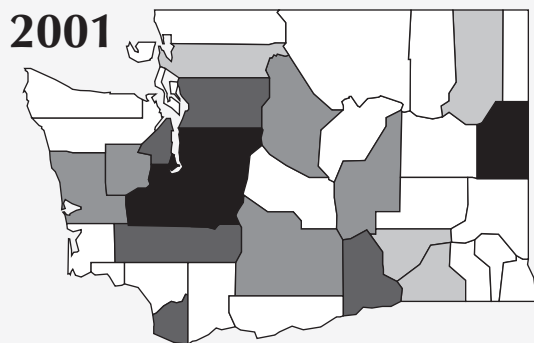
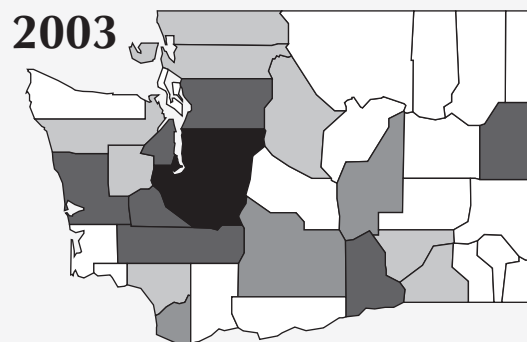
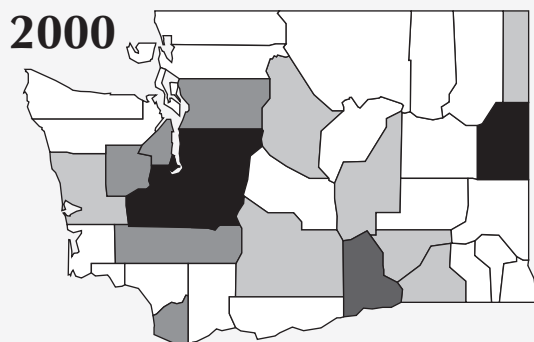
It is likely, but not yet substantiated, that the number of meth lab reports reflects the level of illicit use of the drug in the community. It is also possible, however, that drug dealers are now importing finished product from elsewhere, rather than manufacturing it, and that there is now a smaller number of large labs, accounting for the documented decline. It is now estimated that less than one third of the methamphetamine used in Washington is produced in-state.¹ Anecdotal reports also suggest that meth users may be increasingly turning to heroin use.

¹ Banta-Green, C. *Washington State Drug Use Epidemiology*. Seattle, WA: Alcohol & Drug Abuse Institute, University of Washington, 2003.

Distribution of Methamphetamine Drug Laboratories and Dump Sites Reported by County



Source: Washington State Department of Ecology



These maps indicate that while reports of drug labs and dump sites have declined in the past three years, they are still much more widespread than they were six years ago. In 1994, only one county – Pierce – had as many as a dozen reports. There have been huge increases since then: in Pierce from 17 to 541; King, from 10 to 199; Thurston, from 2 to 61; Spokane, from 1 to 42; Benton, from zero to 57; Skagit, from zero to 31. The epidemic, though now declining, has spread to virtually every part of the state.

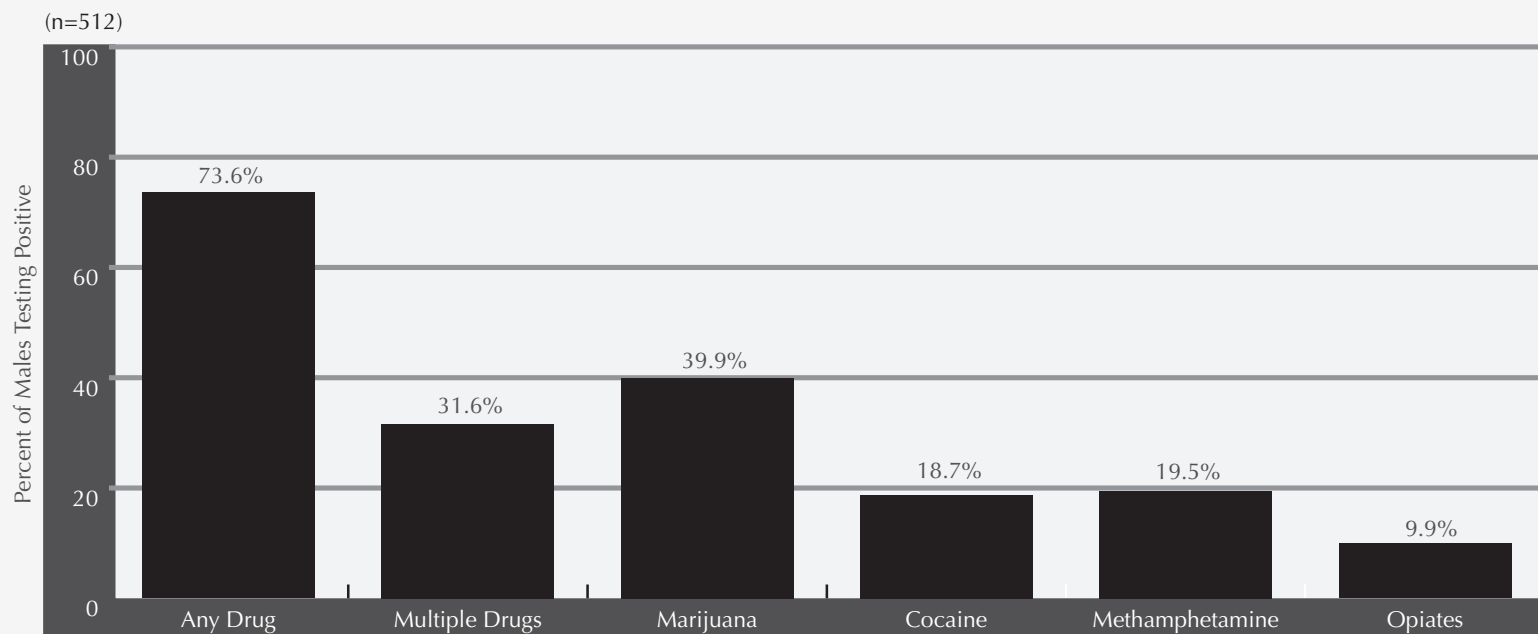


Number of Reported Methamphetamine Laboratories and Dump Sites in Washington State

County	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Adams	-	-	-	1	-	1	-	3	4	4	0
Asotin	-	-	-	-	-	1	1	5	3	4	0
Benton	-	1	3	4	7	38	52	85	87	82	57
Chelan	-	1	1	-	-	2	14	34	15	13	9
Clallam	1	1	1	3	3	-	1	3	10	2	2
Clark	3	3	12	20	12	16	34	57	57	35	28
Columbia	-	-	-	-	-	1	3	2	1	4	1
Cowlitz	-	1	3	9	2	8	7	9	28	18	11
Douglas	-	-	-	-	1	1	6	5	7	4	8
Ferry	-	-	-	-	-	-	7	4	0	0	0
Franklin	-	-	-	-	1	8	10	15	11	13	14
Garfield	-	-	-	-	-	2	-	-	4	1	0
Grant	-	1	-	-	-	2	19	27	46	34	14
Grays Harbor	2	1	3	5	5	16	24	41	32	50	27
Island	-	1	-	1	2	5	1	5	5	14	18
Jefferson	-	-	-	1	1	2	7	6	4	12	2
King	7	10	23	17	48	107	231	271	241	202	199
Kitsap	-	-	3	-	1	21	45	54	60	50	44
Kittitas	-	1	-	-	1	3	-	5	3	5	3
Klickitat	-	1	1	1	3	-	6	4	2	1	0
Lewis	3	4	7	9	31	33	43	61	83	67	30
Lincoln	-	-	-	-	-	-	-	5	3	2	1
Mason	-	-	4	4	10	21	32	30	22	15	31
Okanogan	-	-	-	2	3	2	2	3	3	1	4
Pacific	-	1	-	4	1	6	2	3	4	3	2
Pend Oreille	-	-	-	2	6	10	12	5	12	6	7
Pierce	17	17	53	42	129	318	545	589	438	466	541
San Juan	-	-	-	-	-	-	-	1	1	0	0
Skagit	-	1	-	-	4	2	5	11	34	12	31
Skamania	-	-	-	-	-	2	1	2	3	3	1
Snohomish	-	-	7	6	5	13	37	69	83	98	101
Spokane	1	2	1	7	11	36	137	248	189	91	42
Stevens	-	-	1	1	-	5	4	15	10	3	5
Thurston	2	6	25	63	58	86	139	151	115	96	61
Wahkiakum	-	-	-	-	-	1	-	2	2	2	0
Walla Walla	-	-	-	-	2	8	12	16	15	16	9
Whatcom	-	-	-	-	-	-	-	5	9	24	25
Whitman	-	-	-	-	-	-	1	3	4	0	2
Yakima	-	1	5	1	2	12	14	36	43	27	7
TOTAL	36	54	153	203	349	789	1,454	1,890	1,693	1,480	1,337

Source: Washington State Department of Ecology.

Almost Three Quarters of Male Arrestees Booked Into the Snohomish County Jail Between November 2002 – February 2003 Tested Positive for Drugs.



Source: Gilson, M., and Kabel, J., *The Snohomish County Arrestee Substance Abuse (SCASA) Study*. Olympia, WA: Looking Glass Analytics, 2003.

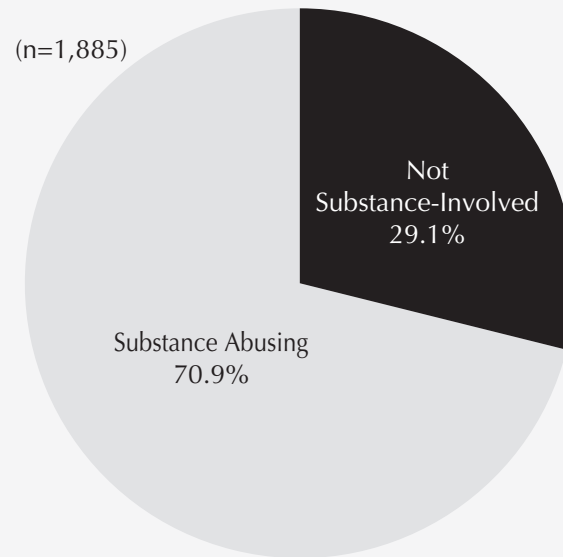
Modeled on an approach pioneered by the recently defunded federal Arrestee Drug Abuse Monitoring Program, males arrested and booked into the Snohomish County Jail between November 2002 – February 2003 were tested for drug use via urine sampling, and interviewed. Almost three quarters (73.6%) tested positive for illicit drugs. Some 39.9% of arrestees were classified as drug-dependent, with 23.7% classified as dependent upon alcohol. Arrestees that reported heavy substance use were more likely to have been arrested in the past 12 months, reported a greater number of lifetime arrests, and reported spending more time in jail than those who did not report heavy substance use.

Only 29% of Snohomish County arrestees reported receiving any treatment for chemical dependency during the previous year.¹

¹ Gilson, M., and Kabel, J. *The Snohomish County Arrestee Substance Abuse (SCASA) Study: Characteristics of Drug Use Among Arrestees Booked Into Snohomish County Corrections Including Comparisons to Booked Arrestees in King and Spokane Counties*. Olympia, WA: Looking Glass Analytics, 2003.



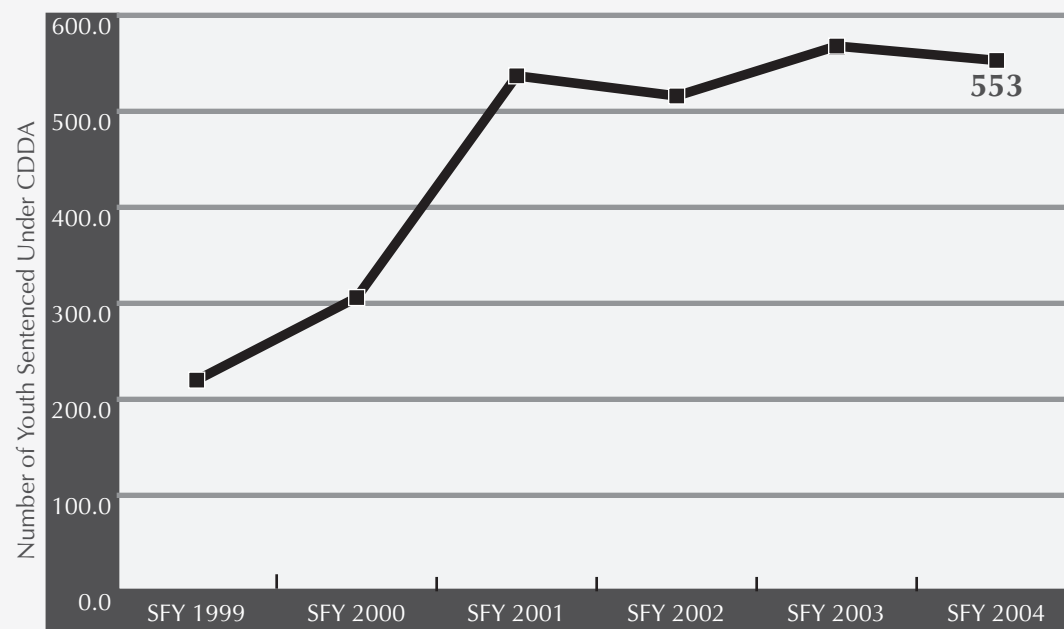
Almost Three Quarters of Youth Entering Juvenile Rehabilitation Administration Facilities in SFY 2004 Had Substance Abuse-Related Problems.



Source: Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services, May 2005.

Almost three out of four youths entering Juvenile Rehabilitation Administration (JRA) institutions have substance abuse-related problems. JRA offers a continuum of chemical dependency treatment services within its facilities. All services are certified by the Division of Alcohol and Substance Abuse (DASA). In SFY 2004, 522 JRA youths received inpatient, intensive outpatient, outpatient, and/or day treatment.

In State Fiscal Year 2004, 553 Youths Who Committed Offenses Received Treatment Under the Chemical Dependency Disposition Alternative.

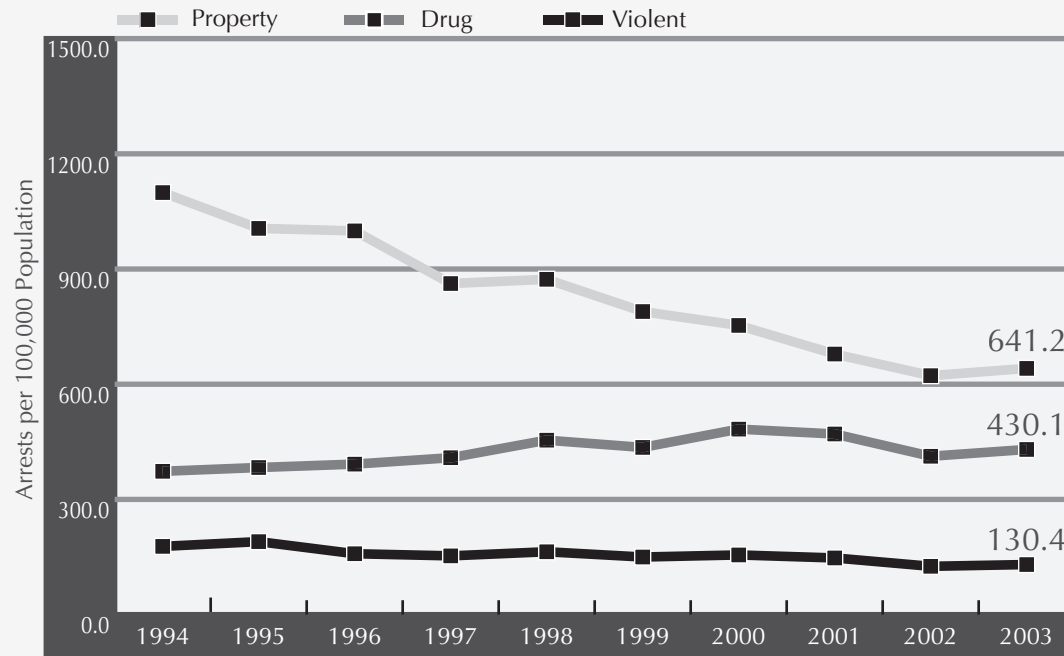


Source: Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services.

In 1998, the Legislature created the Chemical Dependency Disposition Alternative (CDDA). Under CDDA, juvenile courts may sentence chemically abusing and dependent youth to treatment rather than confinement. CDDA represents a collaboration among the Juvenile Rehabilitation Administration, Division of Alcohol and Substance Abuse, Medical Assistance Administration, local juvenile courts, University of Washington, and county alcohol/drug coordinators. A 2004 report to the Legislature prepared by the Alcohol and Drug Abuse Institute, University of Washington, found that committable youth completing CDDA incurred fewer convictions; were less likely to be detained; were more likely to be enrolled in school; were more likely to be working full-time; reported better family and social relationships; and reported fewer emotional difficulties.¹

¹ Rutherford, M., et al. *Report to the Legislature: Chemical Dependency Disposition Alternative*. Olympia, WA: Washington State Department of Social and Health Services, Juvenile Rehabilitation Administration, 2004.

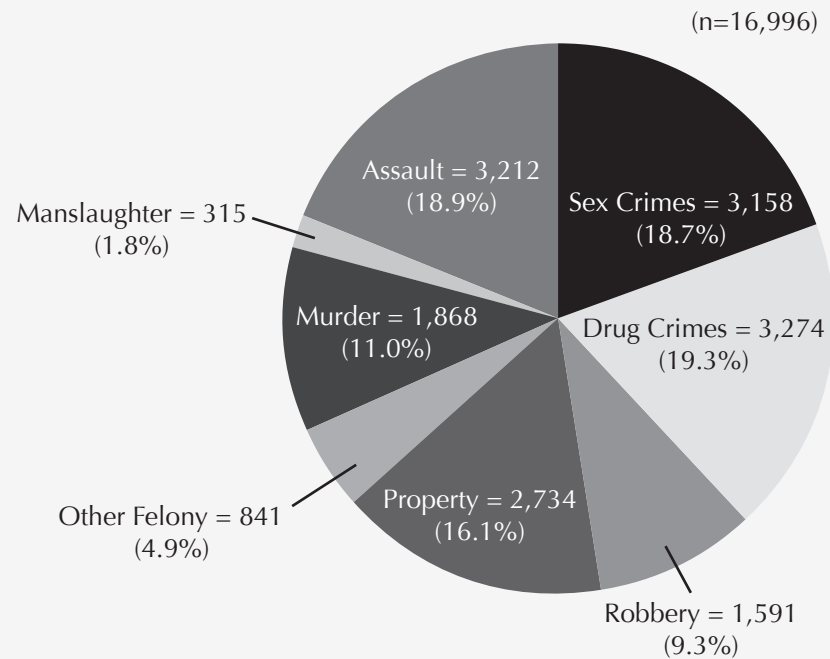
While Arrest Rates for Violent and Property Offenses in Washington State Have Declined, the Drug Arrest Rate Has Increased Since 1993.



Source: Washington Association of Sheriffs and Police Chiefs, *Crime in Washington* annual reports; data adjusted by the Washington State Caseload Forecast Council.

Combined juvenile/adult arrests drug offenses have climbed from 19,769 in 1994 to 26,498 in 2003, a 34.0% increase. Over the past decade, arrests for property crime have dropped precipitously, while arrests for violent crime have declined slowly. Arrest data may reflect a jurisdiction's final resources, enforcement policy, and officer discretion, as well as the actual level of drug-related or other criminal activity.

More Inmates in Department of Corrections Custody are Convicted of Drug Offenses than Any Other Class of Crime.



Source: Washington State Department of Corrections, July 2005.

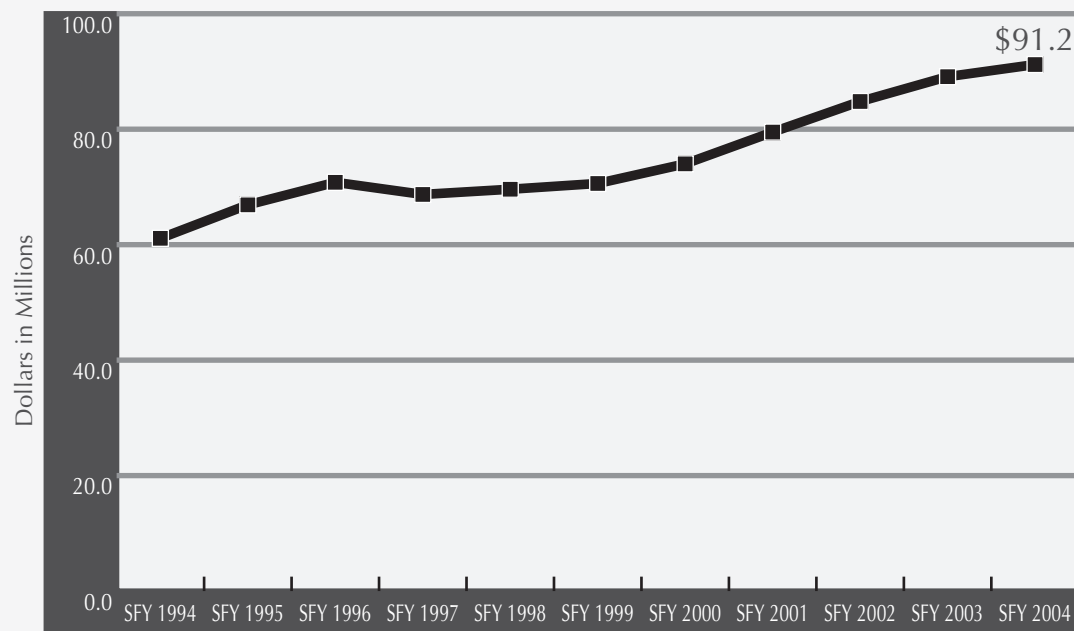
Almost one in five inmates in the custody of the Department of Corrections – in prisons, pre-release facilities, and work release – were convicted of drug offenses, making drug crimes the largest category of offenses. More than half of inmates are estimated to be in need of chemical dependency treatment.¹ Over 50% of males arrested for violent offenses in King and Spokane counties in 2000 tested positive for illegal drugs.²

¹ Washington State Department of Corrections, July 2005.

² Office of Justice Programs. *Arrestee Drug Abuse Monitoring Program 2000 Annualized Site Reports*. Washington, DC: U.S. Department of Justice, National Institute of Justice, 2001.



The Costs of Imprisoning Drug Offenders in Washington State Continue to Rise.*



Source: Washington State Department of Corrections, July 2005.

Costs for imprisoning felony drug offenders in Washington State have grown faster than those for imprisoning other types of offenders. The number of imprisoned drug offenders has increased from 1,822 in SFY 1991 to 3,274 in SFY 2004. Costs for imprisoning offenders is approximately \$73 per day. New sentencing initiatives are now diverting a larger portion of drug offenders into chemical dependency treatment.

**Operating expenses only; excludes capital and supervision costs.*

The Problem: Substance Abuse Prevalence & Trends

AREAS OF
SUBSTANCE
ABUSE
IMPACT

Birth Defects/
Complications

Accident
Risks

Health
Consequences

Infectious
Diseases

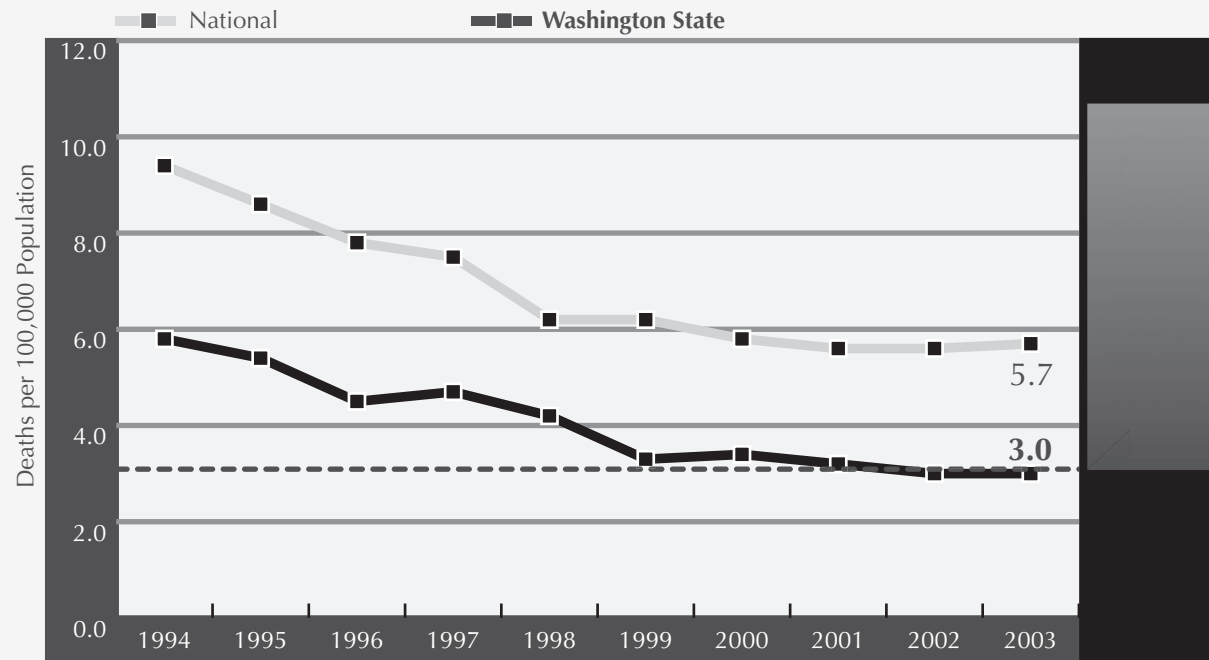
Crime

Violence

Family
Distress



The Homicide Rate in Washington State Continues to Decline.



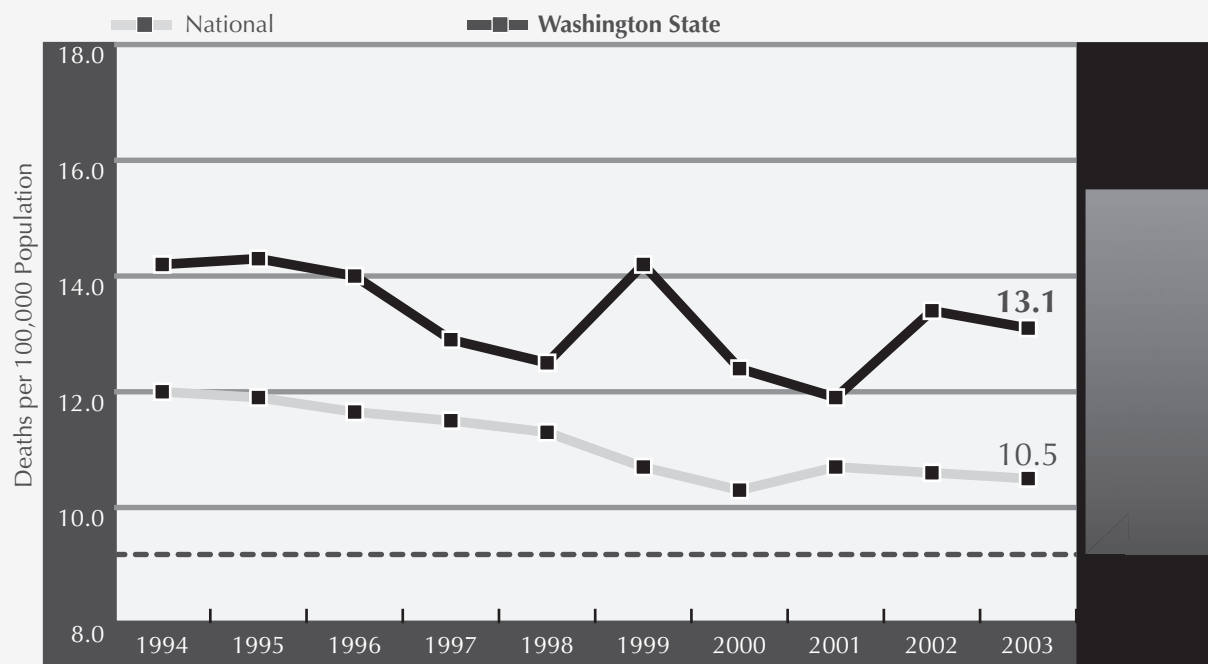
Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from the Washington Association of Sheriffs and Police Chiefs, *Crime in Washington State* annual reports.

There were 184 homicides in Washington State in 2003. Of these, eight were drug-related, and 13 occurred as a result of brawls while under the influence of alcohol. It is unknown how many of the 91 homicides listed as “other”, including the 66 related to child abuse and domestic violence, were associated with alcohol and other drug use.¹

This graph indicates that Washington State’s homicide rate has been lower than the national rate for more than a decade, has dropped significantly since 1995, and is now lower than the *Healthy People 2010* objective.

¹ Washington Association of Sheriffs & Police Chiefs. *Crime in Washington State 2003 Annual Report*. Olympia, WA: 2004.

The Suicide Rate in Washington State is Consistently Higher than the Nation.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Alcohol and drug abuse are closely associated with the risk of suicide. A 1997 study found that use of alcohol almost doubles the risk of suicide in the home, while use of illegal drugs is associated with a seven-fold increase in risk.¹ However, the actual role of alcohol and other drugs in suicide is not clear. Some researchers see alcohol/drug involvement as self-medication to relieve depression or other psychological problems that eventually lead to suicide.² Others suggest that they loosen inhibitions or impair psychological and cognitive process that normally constrain people from suicide.³ Another perspective is that alcohol/drug use is part of the social disintegration that accompanies suicide.⁴

Washington State has a consistently higher suicide rate than the nation. Suicide remains the second leading cause of death among young people ages 15-24 in Washington.

¹ Rivara, F. et al. "Alcohol and Illicit Drug Abuse and the Risk of Violent Death in the Home," *Journal of the American Medical Association* 278(7), 1997.

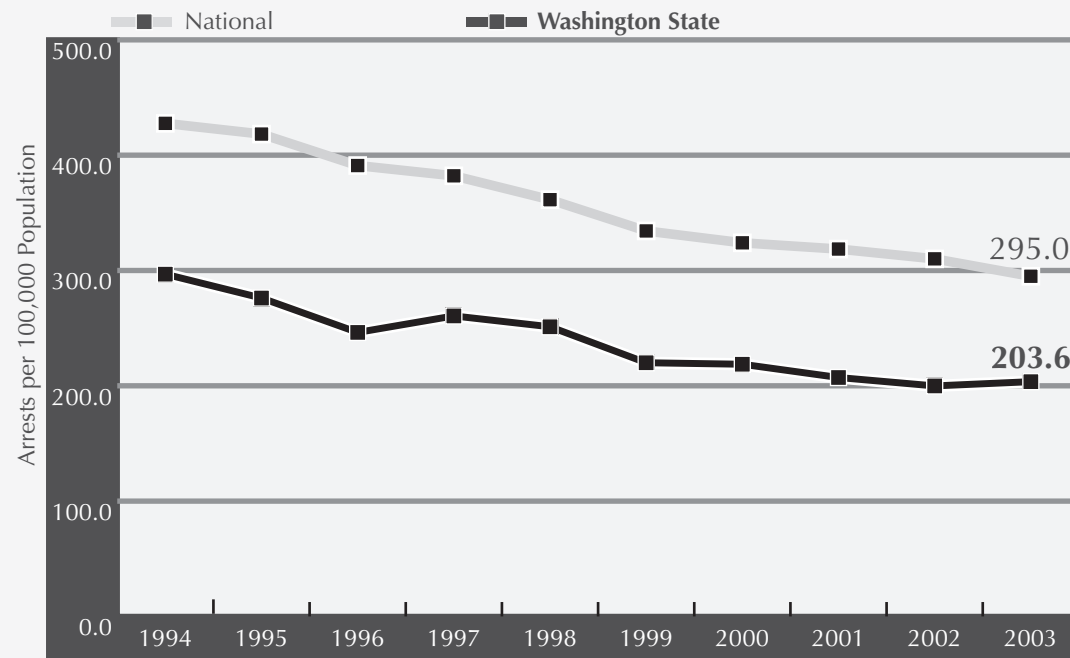
² Shaffer, D. "Suicide: Risk Factors and the Public Health," *American Journal of Public Health* 83, 1993.

³ Zeichner, A. et al. "Alcohol and Aggression: Effects of Personal Threat on Human Aggression and Affective Arousal," *Alcoholism: Clinical and Experimental Research* 18, 1994.

⁴ Yang, B. "The Economy and Suicide," *American Journal of Economics and Sociology* 51, 1992.



The Rate of Aggravated Assaults in Washington State Remains Well Below the National Rate.

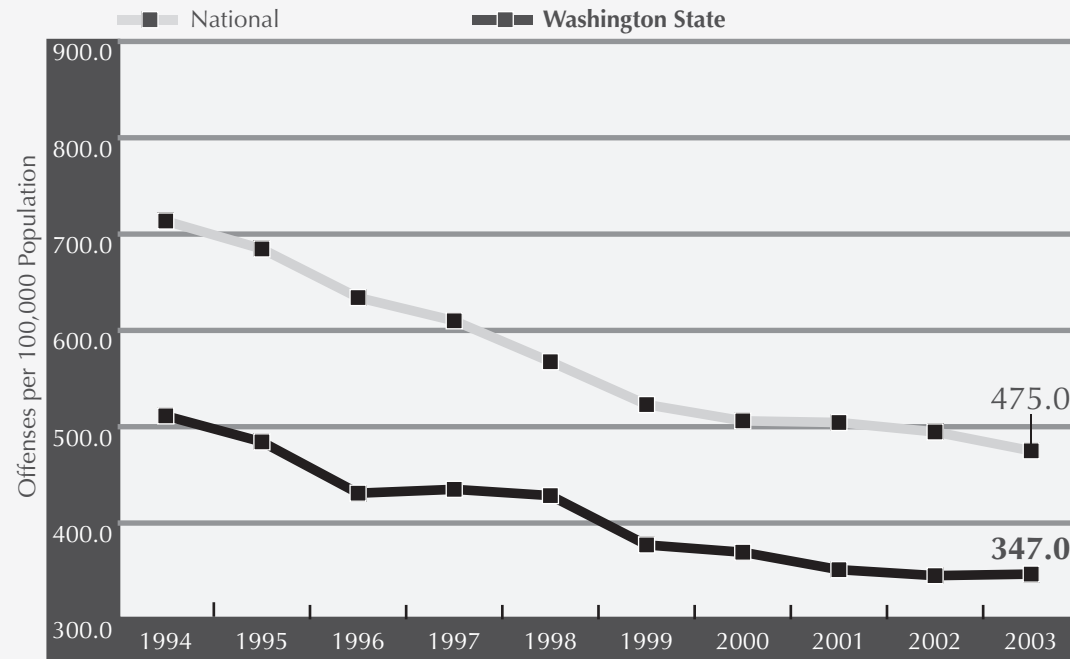


Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State* annual reports.

The federal Uniform Crime Reporting Program defines an aggravated assault as the unlawful attack by one person on another for the purpose of inflicting or aggravating bodily injury. An assault of this type is usually accompanied by the use of a weapon, or by means likely to produce death or severe harm.

This graph indicates that Washington State has a consistently lower rate of aggravated assaults than the nation. The rate has declined 32% since 1994.

Washington State Consistently Has a Lower Rate of Violent Crime than the Nation.



Source: National and state data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports.

This graph indicates that Washington State has had a consistently lower incidence of violent crime than the nation for more than a decade. Violent crime rates are falling, both in the state and the nation. The Arrestee Drug Abuse Monitoring Program found that in 2001, 63.6% of males arrested for violent offenses in King County and 61.6% of males arrested for violent offenses in Spokane County tested positive for illegal drugs.¹

The most serious felony crimes against persons comprise the violent crime index. These offenses include murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. All violent crimes involve force or the threat of force. This index is based upon offenses that become known to police, regardless of whether or not an arrest occurs.

¹ Arrestee Drug Abuse Monitoring Program, Office of Justice Programs, National Institute of Justice. *Drug Use and Related Matters Among Adult Arrestees, 2001*. Washington, DC: U.S. Department of Justice, 2002.

The Problem: Substance Abuse Prevalence & Trends

**AREAS OF
SUBSTANCE
ABUSE
IMPACT**

Birth Defects/
Complications

Accident
Risks

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Consequences

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Diseases

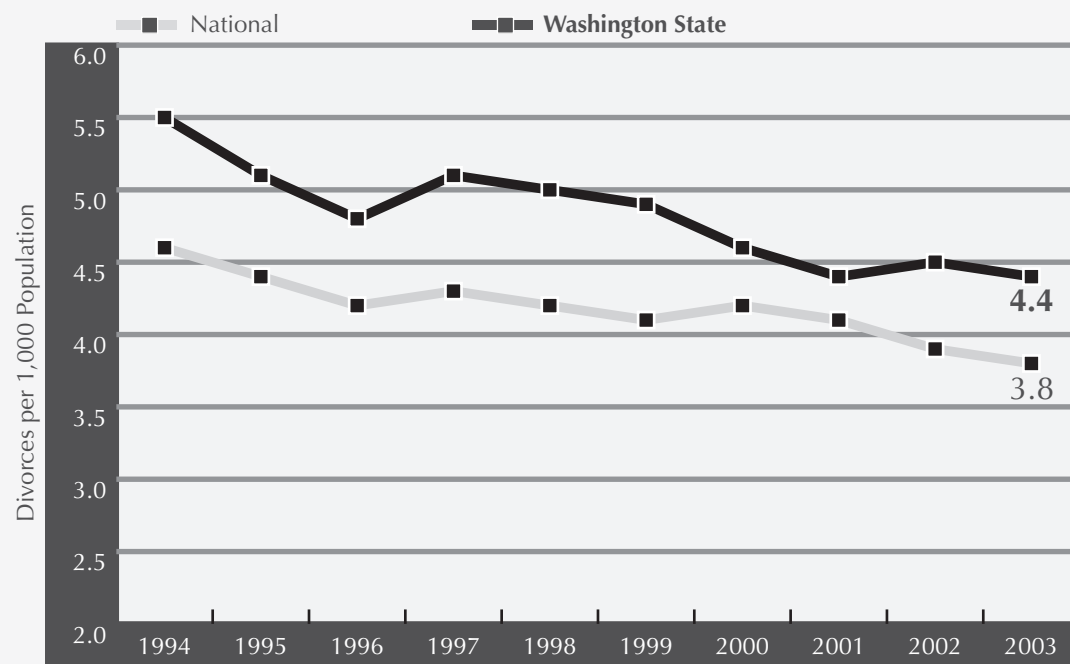
Crime

Violence

Family
Distress



The Divorce Rate in Washington State Has Declined Over the Past Decade.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

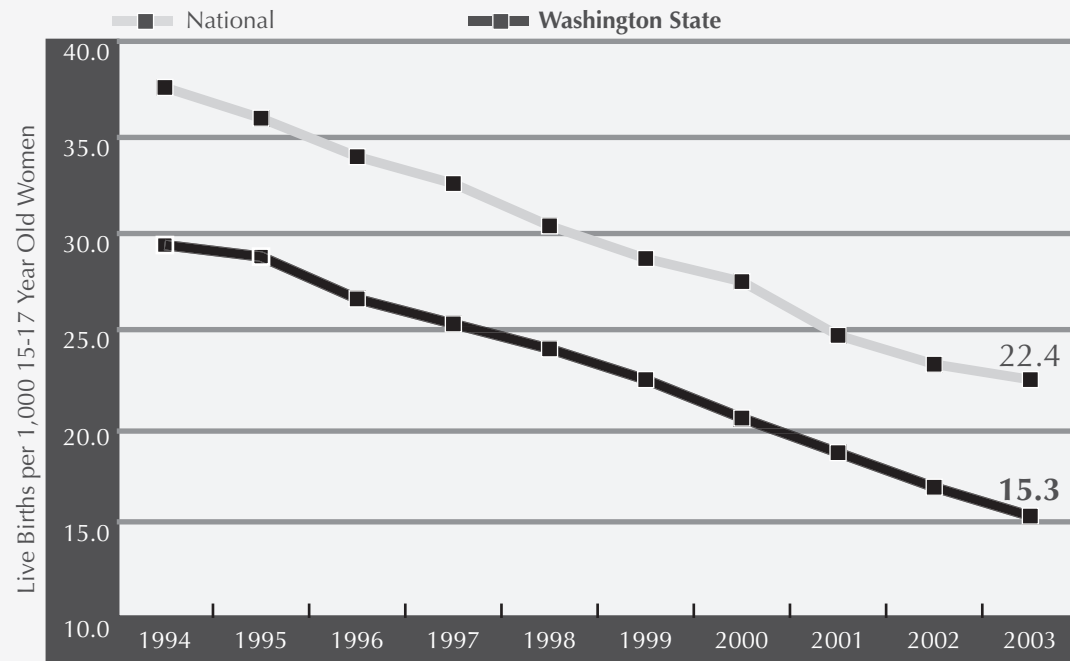
Studies indicate that children from homes broken by marital discord are at a higher risk of drug use.¹

This graph indicates that couples in Washington State experience more divorces (including annulments) than couples nationally. In 2003, at least 51.7% of the 26,710 divorces in Washington State involved families with children.² Caution must be exercised in interpreting divorce rates, as they are computed based on the total population, rather than upon the number of individuals actually married.

¹ Kabel, J. et al. *Profile on Risk and Protection for Substance Abuse Planning in Washington State*. Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, 1997.

² Washington State Department of Health, Center for Health Statistics, 2005.

The Birth Rate Among Teens Ages 15-17 In Washington State and Nationally is in Steep Decline.



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Teen pregnancy has long been associated with alcohol and other drug use. In a survey of women in Washington State who were 18 years old or younger at the time of their first pregnancy, almost one quarter reported having used alcohol or another drug when they first became pregnant, and 36% reported that their partner used alcohol or drugs at that time.¹ Alcohol and drug use in pregnancy is closely associated with a range of health effects among children, including Fetal Alcohol Spectrum Disorders and mental retardation. Maternal age is also a significant risk factor for infant mortality.²

This graph indicates that the rate of births per thousand among teens ages 15-17 is lower in Washington State than the nation, and continues to fall. In 2003, births to women under age 18 represented 2.6% of all births in Washington State.³

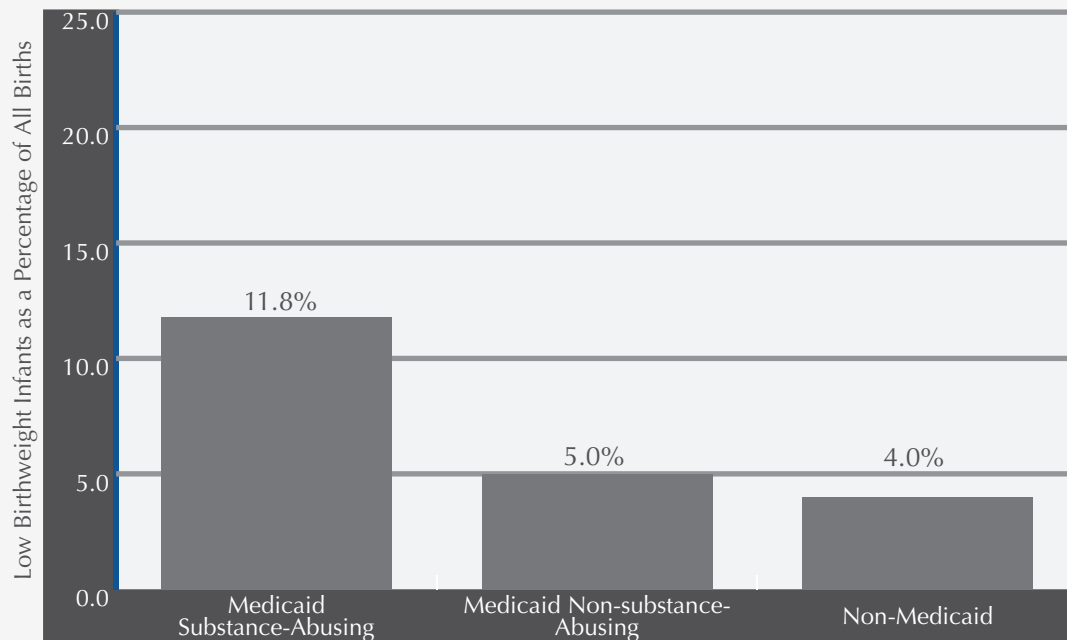
¹ Boyer, D., & Fine D. "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment," *Family Planning Perspectives* 241(1), 1992, 4-12.

² U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-3. Washington, DC: 2000.

³ Washington State Department of Health, Center for Health Statistics, 2005.



Infants Born to Low-Income, Substance-Abusing Women are Much More Likely to Be Low Birthweight.



Source: First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services.

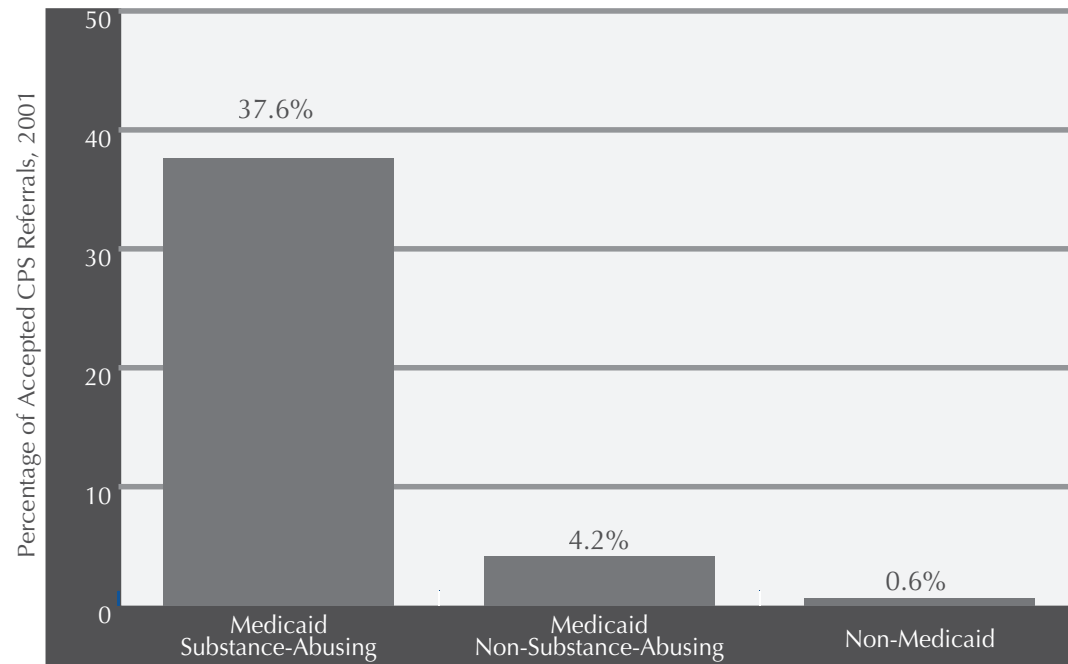
Infants born to low-income, substance-abusing mothers are substantially more likely to be born with low birth weight (LBW), weighing less than 2,500 grams (5 pounds, 8 ounces). This includes those who are born prematurely and those whose intrauterine growth is retarded. LBW is associated with long-term disabilities, including cerebral palsy, autism, mental retardation, hearing impairments, and other developmental problems.¹

Two Washington studies reported fewer LBW births among substance-abusing women who received chemical dependency treatment during pregnancy.²

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4; 16-34. Washington, DC: 2000.

² Krohn, M. "Preliminary Findings for MOMS Project, *Focus*, 1993. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Shrager, L., Kenny, F., and Cawthon, L. *Substance Abuse Treatment for Female DASA Clients: Treatments, Birth Outcomes, and Demographic Profiles*. Olympia, WA: Washington State Department of Social and Health Services, Office of Research and Data Analysis, 1993.

Infants Born to Low-Income, Substance-Abusing Women are More Likely to Be Reported to Child Protective Services as Being at High Risk of Imminent Harm.



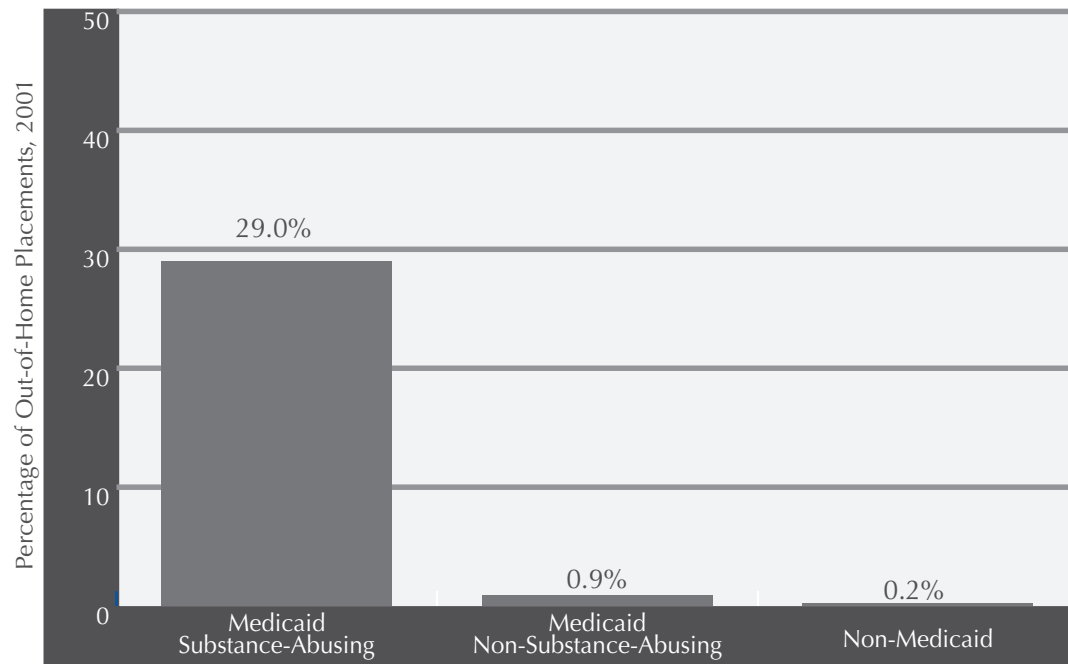
Source: First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services.

Researchers have consistently found an association between alcohol and other drug abuse and virtually all forms of interpersonal violence, including child abuse and neglect. The 2003 Child Maltreatment Report from the federal Children's Bureau found 906,000 substantiated cases of child maltreatment nationwide. Some 61% of reports were for neglect; 19% for physical abuse; 10% for sexual abuse; and 7% for psychological abuse.¹

¹ Children's Bureau. *Children Maltreatment 2003*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, 2005.



Infants Born to Low-Income, Substance-Abusing Women are More Likely to Be Placed Out of Home.



Source: First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services.

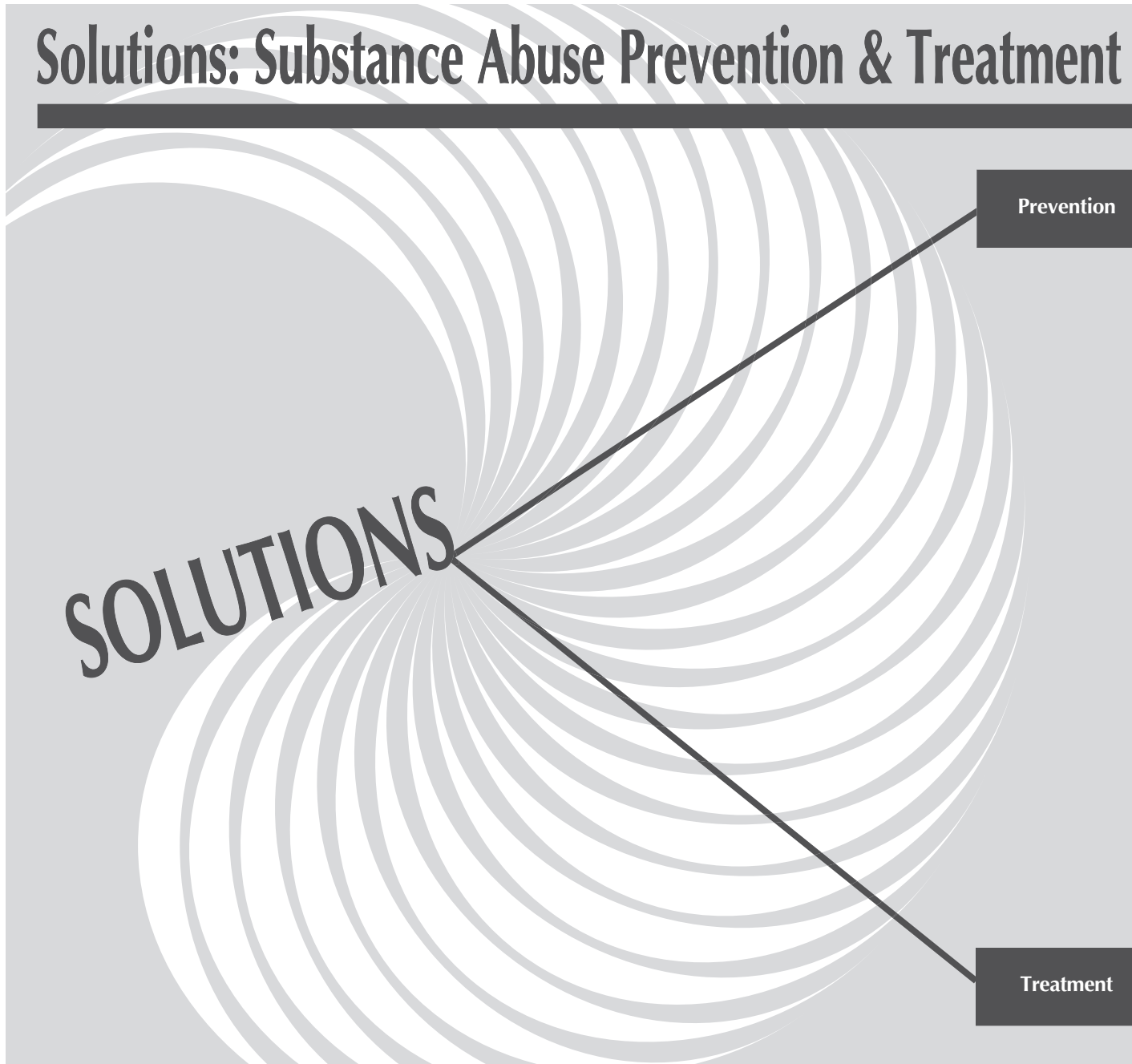
Women receiving Medicaid who are substance abusers are some 30 times more likely to have their infants removed from their care by Child Protective Services and placed out-of-home than women on Medicaid who are not substance abusers. Researchers have consistently found an association between alcohol and other drug abuse and virtually all forms of interpersonal violence, including child abuse and neglect.

Solutions: Substance Abuse Prevention & Treatment

SOLUTIONS

Prevention

Treatment





Introduction

State Law RCW 70.96A identifies the Division of Alcohol and Substance Abuse (DASA) as the “single state” agency for planning and delivery of substance abuse treatment and prevention services. All public substance abuse services funded by state or federal funds are either managed by DASA or operate in coordination with DASA (for example, services provided by the Department of Health, the Department of Licensing, the Department of Corrections, and the Office of the Superintendent of Public Instruction).

DASA does not provide direct prevention or treatment services, but rather, provides these services through contracts with county governments, Indian tribes, and non-profit service providers. The largest portion of available federal and state funds are contracted through county and tribal governments. Each biennium, DASA develops a plan for program development and prevention and treatment service strategies.

County governments and tribes are awarded prevention and treatment funds on the basis of a formula established by DASA in coordination with these governmental units. Counties and tribes are expected to conduct a needs assessment for prevention and treatment needs, based on available funding, and submit a plan to DASA. Contracts for community-based prevention and treatment services are written to include work statements specifying the activities which will be provided under the contracts.

Solutions: Substance Abuse Prevention & Treatment

SOLUTIONS

Prevention

Treatment



Prevention

Washington's youth are faced with choices every day that may result in a variety of problem behaviors. Among the most dangerous of those behaviors is the abuse of alcohol, tobacco, and other drugs. It is the Division of Alcohol and Substance Abuse's (DASA) policy that any use of illicit drugs and the inappropriate use of legal drugs, including alcohol, are considered drug abuse. DASA's goal for the majority of prevention programs it supports is two-fold: programs should act to *delay* the onset of alcohol and tobacco use, and also act to *prevent* the abuse of alcohol, tobacco, and other drugs.

DASA contracts with counties and tribes to provide services at the community level. The Risk and Protective Factor Framework is the cornerstone of all program investments.

Risk and Protective Factor Framework

Over the past two decades, much research has focused on determining how drug abuse begins and how it progresses. Just as medical researchers have found risk factors for heart disease (e.g., lack of exercise, smoking), prevention research has identified a set of risk factors and protective factors related to drug abuse. The more risk factors a child is exposed to, the more likely the child will abuse drugs, alcohol, or tobacco. Some risk factors may be more powerful than others at certain stages in development, such as peer pressure during the teenage years. At each stage, risks occur that can be changed through prevention intervention. Early childhood risks, such as aggressive behavior, can be changed or prevented with family, school, and community interventions that focus on helping children develop appropriate, positive behaviors. If not addressed, negative behaviors can lead to more risks, such as academic failure and social difficulties, which, in turn, put children at further risk for drug abuse later in life.

Not every young person who is exposed to multiple risks becomes a substance abuser, juvenile delinquent, school dropout, or teen parent. There are conditions – known as protective factors – that can counter the risks. Protective factors are buffers in the lives of young people that either reduce the impact of the risk or change the way a person responds to the risk. A strong parent-child bond is an example of a primary protective factor. When children are strongly attached to positive families, friends, schools, and communities, they are more likely to be committed to achieving the goals valued by these groups and are less likely to develop problems as a teenager.

Risk and protective factor-focused prevention programs are based on a simple premise: to prevent a substance abuse problem, we must identify those factors that increase the likelihood of that problem developing and then intervene in ways that reduce the risk. At the same time, we must identify protective factors that buffer individuals from the risks present in their environments and then find ways to strengthen the protection.¹

Many risk factors associated with adolescent substance abuse are also tied to other problem behaviors, including: delinquency, teen pregnancy, school dropout, violence, and depression/anxiety. While the primary focus of prevention programs supported by DASA is substance abuse, addressing its risk factors will likely impact multiple problem behaviors.



Risk and protective factors fall into four domains. Research indicates that by reducing risk factors and enhancing protective factors in each of the domains, the likelihood that youth will engage or experience problem behaviors can be substantially reduced.

The four domains are:

- Community
- Family
- School
- Individual/Peer



Risk Factors and Adolescent Problem Behavior

RISK FACTORS BY DOMAIN

	Substance Abuse	Delinquency	Teen Pregnancy	School Dropout	Violence	Depression/Anxiety
Community						
Availability of Drugs	■				■	
Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime	■	■			■	
Transitions and Mobility	■	■		■		■
Low Neighborhood Attachment and Community Disorganization	■	■			■	
Extreme Economic Deprivation	■	■	■	■	■	
Family						
Family History of the Problem Behavior	■	■	■	■	■	■
Family Management Problems	■	■	■	■	■	■
Family Conflict	■	■	■	■	■	■
Favorable Parental Attitudes and Involvement in the Problem Behavior	■	■			■	
School						
Academic Failure Beginning in Late Elementary School	■	■	■	■	■	■
Lack of Commitment to School	■	■	■	■	■	
Individual/Peer						
Early and Persistent Antisocial Behavior	■	■	■	■	■	■
Rebelliousness	■	■		■		
Friends Who Engage in the Problem Behavior	■	■	■	■	■	
Favorable Attitudes Toward the Problem Behavior	■	■	■	■		
Early Initiation of the Problem Behavior	■	■	■	■	■	
Constitutional Factors	■	■			■	■
Gang Involvement	■	■			■	

Source: Social Development Research Group, University of Washington.



Prevention Works!

In 2003, the Washington State Legislature requested the Washington State Institute for Public Policy examine prevention and early intervention programs for youth. The purpose was to see whether there is credible scientific evidence to indicate that research-based prevention programs can produce benefits for communities that outweigh financial costs. Some 60 programs were evaluated. Their conclusion, published in a report to the Legislature in July 2004, was that certain well-chosen and well-implemented programs, including programs being used in Washington State, can achieve such benefits.¹ Several such programs are profiled on the following pages.

Principles of Effective Substance Abuse Prevention

In Washington State, the Division of Alcohol and Substance Abuse contracts with county prevention providers. Providers are required to use scientifically based best practices for at least 50% of programming. When choosing to design and implement other programs, providers are required to refer to the federal Center for Substance Abuse Prevention's *Principles of Substance Abuse Prevention* and apply the 78 scientifically defensible principles – which are divided by domain – to their work in communities.²

The following pages provide examples of programs being implemented in Washington State that have been scientifically demonstrated to work.

Individual Domain

- Build social and personal skills.
- Design culturally sensitive interventions.
- Cite immediate consequences.
- Combine information dissemination and media campaigns with other interventions.
- Provide positive alternatives to help youth in high-risk environments develop personal and social skills in a natural and effective way.
- Recognize that relationships exist between substance use and a variety of other adolescent health problems.
- Incorporate problem identification and referral into prevention programming.
- Provide transportation to prevention programs.

¹ Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, WA: Washington State Institute for Public Policy, 2004.

² Center for Substance Abuse Prevention. *Principles of Substance Abuse Prevention*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Division of Knowledge Development and Education, 2001. Detailed descriptions of each principle can be found at: www.samhsa.gov/centers/csap/modelprograms/pdfs/pubs_Principles.pdf.

**Family Domain**

- Target the entire family.
- Help develop bonds among parents in programs; provide meals, transportation, and small gifts; sponsor family outings; and ensure cultural sensitivity.
- Help minority families respond to cultural and racial issues.
- Develop parenting skills.
- Emphasize family bonding.
- Offer sessions where parents and youth learn and practice skills.
- Train parents to both listen and interact.
- Train parents to use positive and consistent discipline techniques.
- Promote new skills in family communication through interactive techniques.
- Employ strategies to overcome parental resistance to family-based programs.
- Improve parenting skills and child behavior with intensive support.
- Improve family functioning through family therapy when indicated.
- Explore alternative community sponsors and sites for schools.
- Videotape training and education.

Peer Domain

- Structure alternative activities and supervise alternative events.
- Incorporate social and personal skill-building opportunities.
- Design intensive alternative programs that include a variety of approaches and substantial time commitment.
- Communicate peer norms against use of alcohol and illicit drugs.
- Involve youth in the development of alternative programs.
- Involve youth in peer-led interventions, or interventions with peer-led components.
- Counter the effects of deviant norms and behaviors by creating an environment for youth with behavior problems to interact with other nonproblematic youth.



School Domain

- Avoid relying solely on knowledge-oriented interventions designed to supply information about negative consequences.
- Correct misconceptions about the prevalence of use in conjunction with other education approaches.
- Involve youth in peer-led interventions or interventions with peer-led components.
- Give students opportunities to practice newly acquired skills through interactive approaches.
- Help youth retain skills through booster sessions.
- Involve parents in school-based approaches.
- Communicate a commitment to substance abuse prevention in school policies.

Community Domain

- Develop integrated, comprehensive prevention strategies rather than one-time community-based events.
- Control the environment around schools and other areas where youth gather.
- Provide structured time with adults through mentoring.
- Increase positive attitudes through community service.
- Achieve greater results with highly involved mentors.
- Emphasize the costs to employers of workers' substance use and abuse.
- Communicate a clear company policy on substance abuse.
- Include representatives from every organization that plays a role in fulfilling coalition objectives.
- Retain active coalition members by providing meaningful rewards.
- Define specific goals and assign specific responsibility for their achievement to subcommittees and task forces.
- Ensure planning and clear understanding for coalition effectiveness.
- Set outcome-based objectives.
- Support a large number of prevention activities.
- Organize at the neighborhood level.
- Assess progress from an outcome-based perspective and make adjustments to the plan of action to meet goals.
- Involve paid coalition staff as resource providers and facilitators rather than as direct community organizers.



Society/Environmental Domain

- Develop community awareness and media efforts.
- Use mass media appropriately.
- Provide structured time with adults through mentoring.
- Avoid the use of authority figures.
- Broadcast messages frequently over an extended period of time.
- Broadcast messages through multiple channels when the target audience is likely to be viewing or listening.
- Disseminate information about the hazards of a product or industry that promotes it.
- Promote replacement of more conspicuous labels.
- Promote restrictions on tobacco use in public places and private workplaces.
- Promote clean indoor air laws.
- Combine beverage server training with law enforcement.
- Combine beverage servers' legal liability with laws against service to intoxicated patrons and against sales to minors.
- Increase the price of alcohol and tobacco through excise taxes.
- Increase minimum purchase age for alcohol to 21.
- Limit the location and density of retail alcohol outlets.
- Employ neighborhood anti-drug strategies.
- Enforce minimum purchase age laws using undercover buying operations.
- Use community groups to provide positive and negative feedback to merchants.
- Employ more frequent enforcement operations.
- Implement "use and lose" laws.
- Enact deterrence laws and policies for impaired driving.
- Enforce impaired-driving laws.
- Combine sobriety checkpoints with positive passive breath sensors.
- Revoke licenses for impaired driving.
- Immobilize or impound vehicles of those convicted of impaired driving.
- Target underage drivers.



Prevention Works!

Prevention programs address risk and protective factors in four domains. Research indicates that by reducing risk factors and enhancing protective factors in each of the domains, the likelihood that youth will engage or experience problem behaviors can be substantially reduced. Below are descriptions of programming in each domain, and a description of programs being utilized in each domain among Washington's counties and tribes.

Community Domain Programming

In community domain programming, anti-drug norms and pro-social behaviors are strengthened through the involvement of civic, religious, law enforcement, and other government organizations. Many programs coordinate prevention efforts to communicate consistent messages through school, work, religious institutions, and the media. Research has shown that programs that reach youth through multiple settings can strongly impact community norms. Community-based programs may also include policy development, law enforcement, mass media efforts, and community-wide awareness efforts. Some carefully structured and targeted media interventions have proven to be very effective in reducing drug abuse.

To determine the level of risk/protective factors in the community domain, both archival and data from the Adolescent Health Behavior Survey are utilized. Archival indicators include: number of alcohol sales outlets and tobacco distributors; number of children in families receiving some form of public assistance; population not voting in elections; and net migration. Survey indicators include: perceived availability of drugs; laws and norms favorable to drug use; personal transitions and mobility; and opportunities and rewards for pro-social involvement.

The following community evidence-based programs and strategies were implemented in Washington counties and tribes in the 2003-2005 Biennium:

Communities that Care® (CTC) provides research-based tools to guide communities through a process leading to a place to promote the positive development of children and youth, and prevent adolescent problem behaviors that impede positive development. Implemented in Cowlitz and Snohomish Counties.

Community Trials Intervention to Reduce High-Risk Drinking is a multi-component program developed to alter alcohol use patterns of people of all ages, to combat drinking and driving, underage drinking, binge drinking, and related problems. Implemented in Kittitas County.

Counter-Advertising uses the media to promote negative images about tobacco use, reveal the number of teens who actually use tobacco, and emphasize the unacceptability of tobacco use. It counters tobacco industry advertising that links tobacco use with peer acceptance, success, and good times. Implemented in Whitman County.

Project Northland consists of social-behavioral curricula in schools, peer leadership training among youth to increase peer pressure resistance and social competence skills, parental involvement/education to provide parental support and modeling, and community-wide taskforce activities aimed at changing the larger environment. Implemented in Mason County.



Retail-Directed Interventions include merchant and community education about adolescent tobacco use and laws prohibiting tobacco sales to minors, and enactment and enforcement of laws prohibiting tobacco sales to minors. Implemented in Grays Harbor and Kitsap Counties.

Tobacco-Free Environmental Policies are directed at creating environments where youth are not exposed to the possession and use of tobacco. Activities include: reviewing existing laws and compliance with laws restricting tobacco use; reviewing the effects of anti-smoking school policies on adolescent smoking; providing technical assistance and guidance on developing and implementing tobacco-free policies and environments.



Family Domain Programming

Risk factors are reduced among young children by teaching parents better family management practices, such as communication skills, appropriate discipline styles, and firm and consistent rule enforcement. Research confirms the benefits of parents providing consistent rules and discipline, talking to children about drugs, monitoring their activities, getting to know their friends, understanding their problems and concerns, and being involved in their learning. The importance of the parent-child relationship continues through adolescence.

Archival indicators are used to determine the level of risk/protective factors in the family domain. These include: divorce rates; domestic violence arrests; percentage of adults in chemical dependency treatment programs; alcohol- and drug-related deaths; percentage of children living in foster care or away from home; number of victims in accepted referrals to Child Protective Services.

The following community evidence-based programs and strategies were implemented in Washington counties and tribes in the 2003-2005 Biennium:

Creating Lasting Family Connections assists high-risk youth ages 11-15 and their families to become strong, healthy, and mutually supportive. The program provides parents and youth with defenses against environmental risk factors by teaching appropriate skills for personal growth, family enhancement, and interpersonal communication, including refusal skills for both parents and youth. Implemented in King County.

Families in Action is a program aimed at families in rural school districts with students entering middle or junior high school. Implemented in Skamania County.

Guiding Good Choices® (formerly known as Preparing for the Drug-Free Years) is a multi-media program that provides parents of children in 4th through 8th grades the knowledge and skills necessary to guide their children through early adolescence. The program aims to strength and clarify family expectations for behavior, enhance the conditions that promote bonding in the family, and teach skills to parents and children to successfully meet the expectations of their family and resist alcohol, drug, and tobacco use. Implemented in Benton/Franklin, King, and Yakima Counties.

Home Visiting provides a bridge between a parent with a young child and the outside world by way of a visitor who cares about the raising of children. The visitor may provide information and/or emotional support. Visitors may be trained in health (e.g. nurses), human development (psychologists or social workers), cognitive and social skills instruction (preschool teachers), or some combination (paraprofessionals). Implemented in Clallam County.

Incredible Years helps parents improve communication skills with their children, enhance limit-setting skills by means of nonviolent discipline techniques, develop their own problem-solving skills, and learn effective methods of anger management. Implemented in Clallam and Yakima Counties.



NICASA Parenting Project is implemented in the workplace and enriches family relationships and promotes healthy environments that build resistance to social and personal dysfunction. It focuses on the need to establish supportive networks among working parents, improve parent/child relationships, increase ability to balance work and family life, enhance the corporate climate for workers, and improve parenting skills. Implemented in Clark County.

Nurturing Programs are family-centered and build nurturing skills as alternatives to abusive childrearing attitudes and practices. Implemented in Ferry, King, Lewis, Spokane, and Whitman Counties.

Parenting Skills Programs teach communication and child management skills in order to improve parent-child relationships and foster good psychosocial adjustment in children. Implemented in King County.

Parenting Wisely is an interactive CD-ROM-based program designed for at-risk families with children from early elementary to high school age. This format overcomes illiteracy barriers, thereby meeting the needs of families who do not usually attend or finish parenting education. It seeks to help families enhance relationships and decrease conflict through behavior management and support, and builds confidence in parenting skills. This program has been presented in Spanish, as well as English. Implemented in Thurston County.

Parent and Family Skills Programs enable families to better nurture and protect their children, help children develop pro-social behaviors, and train families to deal with particularly challenging children. Implemented in Kitsap County.

Parents as Teachers is an early childhood parent education and support program serving families from pregnancy through kindergarten. The program provides: 1) personal visits – certified parent educators help parents understand and have appropriate expectations for each stage of their child's development; 2) group meetings – parents meet to enhance their parenting knowledge, gain new insights and share their experiences, common concerns, and successes; 3) developmental screenings – periodic screening of overall development, health, hearing, and vision to provide early detection of potential problems and prevent later difficulties in school; and 4) linkage to a resource network – families are assisted in accessing other needed community services. Implemented in Garfield County.

Parents Who Care is a skill-building program created for families with children between ages 12-16. It is grounded in the social development model, emphasizing that young people should experience opportunities for active involvement in family, school, and community, develop skills for success, and be given recognition and reinforcement for positive effort and improvement. It focuses on strengthening family bonds and establishing clear standards for behavior, helping parents more appropriately manage their teenager's behavior while encouraging their adolescent growth toward independence. Implemented in Clallam and Okanogan Counties.



Storytelling for Empowerment is based on the understanding that storytelling has been used for centuries by humans to pass on values and cultural identity, and as such is a natural vehicle for nurturing resiliency factors in youth. This approach enhances the buffering effects of a positive peer group and a positive cultural identity. It is designed for club and classroom settings serving American Indian and Latino-Latina middle school youth. The program addresses the confusion of cultural identity, the lack of congruence of multicultural learning styles and instruction, and the lack of consistent, positive parental role models. Implemented in King County.

Strengthening Families Program involves elementary school children ages 6-12 and their families in family skills training sessions. It uses family systems and cognitive/behavioral approaches to increase resiliency and reduce risk factors for behavioral, emotional, academic, and social problems. It builds on protective factors by improving family relationships, enhancing parenting skills, and increasing the youth's social and life skills. Implemented in Cowlitz, Garfield, Grant, Grays Harbor, Mason, Pend Oreille, Skagit, Thurston, and Wahkiakum Counties.

Strengthening Families Program: For Parents and Youth 10-14 resulted from an adaptation of the Strengthening Families Program (SFP). It focuses on improving parental skills in nurturing and child management, and enhancing interpersonal and personal competencies and pro-social skills among youth. Videotapes portraying pro-social behaviors are utilized and are appropriate for multi-ethnic families. This program has been presented in English and Spanish. Implemented in Adams, Asotin, Benton/Franklin, Chelan/Douglas, Columbia, Ferry, Island, King, Lewis, Lincoln, Okanogan, San Juan, Skagit, Spokane, Stevens, Wahkiakum, Whatcom, and Yakima Counties, and the Spokane Tribe.

Strengthening Multi-Ethnic Families and Communities targets ethnic minority parents of children ages 3-18 who are interested in raising children with a commitment to leading a violence-free, healthy lifestyle. Short-term objectives are to increase parents' sense of competence, positive family/parent/child interactions and relationships, child self-esteem and self-discipline, child social competency skills, and increased parental involvement in churches, schools, community agencies, and other locations. Implemented in King, Pierce, and Snohomish Counties.



School Domain Programming

School domain programming focuses on the social and academic skills of children, including peer relationships, self-control, coping, and drug-refusal skills. School-based prevention programs are most successful when integrated into the academic program, because school failure is strongly associated with drug abuse. Integrated programs strengthen the student-school bond and reduce the likelihood of dropping out. Other types of interventions include school-wide programs that affect the school environment as a whole. All of these activities can serve to strengthen protective factors against drug abuse.

Both archival and Adolescent Health Behavior Survey data are used to determine the risk/protective factors in this domain. Archival data include: high school dropout rates; academic failure; and poor academic performance in grades 4 and 8. Survey data include: commitment to school; and opportunities for pro-social involvement.

The following community evidence-based programs and strategies were implemented in Washington counties and tribes in the 2003-2005 Biennium:

Tutoring Programs improve academic success among elementary school children who have serious academic problems in reading and/or mathematics. Initial tutoring sessions involve an assessment of the child's successes and failures in regular classroom reading material. Tutors are trained in the use of behavior techniques to help children attempt tasks they would otherwise avoid. Implemented in Kitsap and Pierce Counties.

Across Ages is a school- and community-based program for youth ages 9-13 that seeks to strengthen the bonds between adults and youth, and provide opportunities for positive community involvement. A unique feature of Across Ages is the pairing of older adult mentors (age 55 and above) with young adolescents, specifically youth making the transition to middle school. The program employs mentoring, community service, social competence training, and family activities to build youths' sense of personal responsibility for self and community. Implemented in Benton/Franklin Counties.

PAL® Peer Assistance and Leadership Programs are driven by needs assessment and include the following: group and one-to-one peer tutoring and mentoring; activities and group discussions on issues such as alcohol and substance use, and career choices; peer mediation and conflict resolution services; and participation in community service projects. The programs seek to develop communication, decision-making, problem-solving, team and relationship-building, and refusal skills. Implemented in Pend Oreille and Walla Walla Counties.



Individual/Peer Domain Programming

In individual/peer domain programming is primarily directed at enhancing protective factors. Positive bonding is one of the protective factors that can buffer a young person who is exposed to multiple risk factors. Bonding is most likely to occur when youth are given opportunities to contribute in a meaningful way to their community, family, peers, and/or school; are taught the skills necessary to be successful in that opportunity; and are recognized for their efforts. Individuals are also provided information about the negative consequences of risky behaviors, including substance abuse.

Both archival and Adolescent Health Behavior Survey data are utilized in determining the level of risk in the individual/peer domain. Archival data include: alcohol- and drug-related arrests, ages 10-14; property crime arrests, ages 10-14; and vandalism arrests, ages 10-14. Survey data include: rebelliousness; antisocial behavior; friends' use of drugs; interaction with antisocial peers; favorable attitudes toward drug use and/or antisocial behavior; perceived risks of drug use; perceived rewards for antisocial behavior; and early initiation of problem behaviors.

The following community evidence-based programs and strategies were implemented in Washington counties and tribes in the 2003-2005 Biennium:

All Stars comes in two formats: middle school classroom- and community-based formats. Each reinforces the belief that risky behaviors are not normal or acceptable by the adolescent's peer group; cultivates the belief that risky behaviors do not fit with the youth's personal ideals and future aspirations; creates strong, voluntary personal and public commitments to not participate in risky behaviors; strengthens relationships between adolescents, social institutions, and significant adults; and helps parents listen to their children, communicate clear no-use expectations about alcohol and other drugs, and support their children in working toward positive life goals. Implemented in Ferry, Grant, King, and Pacific Counties.

Big Brothers/Big Sisters is a mentoring program that matches an adult volunteer with a child, with the expectation that a caring and supportive relationship will develop. A professional staff member selects, matches, monitors, and closes the relationship with the volunteer and child, and communicates with the volunteer, parent/guardian, and the child throughout the matched relationship. Implemented in Clark, Ferry, Island, Jefferson, King, Pierce, San Juan, Skamania, Snohomish, Spokane, and Whatcom Counties, and the Jamestown S'Klallam Tribe.

Brys Behavioral Monitoring and Reinforcement Program is a school-based, early intervention program based on behavior modification and teaching thinking skills. The program targets 7th and 8th graders and includes the following components: recording daily attendance and discipline referrals of program participants, weekly discussions with students in small groups about what to do to improve their teacher's impression of their behavior, and rewarded for every day that they come to school, arrive on time, and receive no disciplinary action. Implemented in Island and Spokane Counties.

Friendly PEERsuasion® is directed at girls of middle school age, ages 11-14, to help them acquire the knowledge, skills, and support systems to avoid substance abuse. Implemented in Walla Walla County.

LifeSkills®Training is a three-year prevention curriculum intended for middle school or junior high school students. It covers three major content areas: drug resistance skills and information, self-management skills, and general social skills.



Implemented in Chelan/Douglas, Ferry, Grant, King, Pend Oreille, Pierce, Skagit, Skamania, Snohomish, Walla Walla, Whitman, and Yakima Counties, and the Upper Skagit Tribe.

PATHS (Promoting Alternative Thinking Strategies) seeks to promote emotional and social competencies and reduce aggression and behavior problems in elementary school-aged children, while simultaneously enhancing the educational process in the classroom. Educators and counselors use it in classroom settings. Although it focuses primarily on the students, information and activities are included for use with parents. Implemented in Thurston County.

Positive Action aims to improve the academic achievement and behavior of children and adolescents. It is intensive, with lessons at each grade level from kindergarten through 12th grade that are reinforced all day, school-wide, at home, and in the community. Components can stand alone, and are useful in a variety of settings beyond the school. Implemented in Spokane County.

Project ALERT is a school-based, social resistance approach that specifically targets cigarettes, alcohol, and marijuana use. Implemented in Adams, Benton/Franklin, Garfield, Jefferson, King, Pacific, Pierce, and Whatcom Counties, and the Puyallup Tribe.

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) provides a full range of substance use prevention and early intervention services. The program places highly trained professionals in schools to work with high-risk youth ages 14-18. Implemented in Kittitas and Klickitat Counties.

Project Towards No Drug Abuse provides detailed information to older teens about the social and health consequences of drug use. The program also provides instruction in active listening, effective communication skills, stress management, tobacco cessation techniques, and self-control. Implemented in Pierce County.

Second Step is a classroom-based social skills program for preschool through junior high students. It aims at reducing aggressive behaviors and increasing children's social-emotional competence. Implemented in Pend Oreille and Spokane Counties.

Sembrando Salud is a culturally sensitive anti-tobacco and alcohol use program specifically adapted for migrant Hispanic youth and their families. The program enhances parent-child communication skills as a way of improving and maintaining healthy youth decision-making. It utilizes a school and family curriculum delivered by bilingual/bicultural college students. Implemented in Skagit County.

SMART Leaders is a two-year booster program for youth who have completed "Stay SMART," a component of Boys & Girls Clubs of America's SMART Moves program. It reinforces the substance abuse prevention skills and knowledge of the first program, with sessions on self-concept, coping with stress, and resisting media pressures. Implemented in Jefferson and Whatcom Counties.

Keep A Clear Mind is a parent/child program for families with children in grades 4 through 6. This home-based program uses a correspondence format and consists of lessons on alcohol, tobacco, marijuana, and tools to avoid drugs. The overall goal is to increase parent/child communication, and to develop specific youth beliefs and skills to refuse and avoid "gateway" drug use. Implemented in Pacific, Stevens, and Walla Walla Counties.

County Prioritized Risk Factors



The table below displays a summary of the prioritized risk factors for the 2003-2005 Biennium being addressed by each of the 39 counties in Washington State.

TARGETED RISK FACTORS	COUNTY	Adams	Asotin	Benton-Franklin	Chelan-Douglas	Clallam	Clark	Columbia	Cowlitz	Ferry	Garfield	Grant	Grays Harbor	Island	Jefferson	King	Kitsap	Kittitas	Klickitat	Lewis	Lincoln	Mason	Okanogan	Pacific	Pend Oreille	Pierce	San Juan	Skagit	Skamania	Snohomish	Spokane	Stevens	Thurston	Wahkiakum	Walla Walla	Whatcom	Whitman	Yakima	
Academic Failure Beginning in the Late Elementary School																																							
Availability of Alcohol/Drugs																																							
Community Laws and Norms																																							
Constitutional Factors																																							
Early & Persistent Antisocial Behavior																																							
Early Initiation of the Problem Behavior																																							
Extreme Economic Deprivation																																							
Family Conflict																																							
Family History of Problem Behavior																																							
Family Management Problems																																							
Favorable Attitudes Toward the Problem Behavior																																							
Favorable Parental Attitudes & Involvement in the Problem Behavior																																							
Friends Who Engage in the Problem Behavior																																							
Lack of Commitment to School																																							
Low Neighborhood Attachment & Community Disorganization																																							
Rebelliousness																																							
Transitions and Mobility																																							

Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.



County Prioritized Protective Factors

The table below displays a summary of prioritized protective factors for the 2003-2005 Biennium being addressed by each of the 39 counties in Washington State.

TARGETED PROTECTIVE FACTORS ▼	COUNTY	Adams	Asotin	Benton-Franklin	Chelan-Douglas	Clallam	Clark	Columbia	Cowlitz	Ferry	Garfield	Grant	Grays Harbor	Island	Jefferson	King	Kitsap	Kittitas	Klickitat	Lewis	Lincoln	Mason	Okanogan	Pacific	Pend Oreille	Pierce	San Juan	Skagit	Skamania	Snohomish	Spokane	Stevens	Thurston	Wahkiakum	Walla Walla	Whatcom	Whitman
Community: Bonding (opportunity, skills, and recognition)		■					■	■					■		■					■						■	■	■	■	■							
Community: Healthy Beliefs and Clear Standards																■				■																	
Family: Bonding (opportunity, skills, and recognition)		■			■					■						■				■																	
Family: Healthy Beliefs and Clear Standards																■																					
Peer: Bonding (opportunity, skills, and recognition)																■																■				■	■
Peer: Healthy Beliefs and Clear Standards																■												■				■			■		
School: Bonding (opportunity, skills, and recognition)																■										■	■										
School: Healthy Beliefs and Clear Standards																■																					

Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.

Tribal Prioritized Risk Factors



The table below displays a summary of the prioritized risk factors for the 2003-2005 Biennium being addressed by 22 tribes in Washington State that have prevention contracts with the Division of Alcohol and Substance Abuse.

TARGETED RISK FACTORS	TRIBE	Hoh	Jamestown S'Klallam	Kalispel Tribe of Indians	Lower Elwha Klallam	Makah	Muckleshoot	Nisqually	Puyallup	Quileute	Quinault Nation	Samish Nation	Sauk-Suiattle	Shoalwater Bay	Skamania	Skokomish	Snoqualmie	Spokane Tribe of Indians	Squaxin Island	Stillaguamish	Suquamish	Swinomish	Tulalip	Upper Skagit	Yakama Nation
Academic Failure Beginning in the Late Elementary School																									
Availability of Alcohol/Drugs																									
Community Laws and Norms																									
Early + Persistent Antisocial Behavior																									
Early Initiation of the Problem Behavior																									
Extreme Economic Deprivation																									
Family Conflict																									
Family History of Problem Behavior																									
Family Management Problems																									
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Favorable Parental Attitudes & Involvement in the Problem Behavior																									
Friends Who Engage in the Problem Behavior																									
Lack of Commitment to School																									
Low Neighborhood Attachment & Community Disorganization																									
Rebelliousness																									
Transitions and Mobility																									

Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.



Tribal Prioritized Protective Factors

The table below displays a summary of the prioritized protective factors for the 2003-2005 Biennium being addressed by 22 tribes in Washington State that have prevention contracts with the Division of Alcohol and Substance Abuse.

TARGETED PROTECTIVE FACTORS ▼	TRIBE	Hoh	Jamestown S'Klallam	Kalispel Tribe of Indians	Lower Elwha Klallam	Makah	Muckleshoot	Nisqually	Puyallup	Quileute	Quinault Nation	Samish Nation	Sauk-Suiattle	Shoalwater Bay	Skamania	Skokomish	Snoqualmie	Spokane Tribe of Indians	Squaxin Island	Stillaguamish	Suquamish	Swinomish	Tulalip	Upper Skagit	Yakama Nation
Community: Bonding (opportunity, skills, and recognition)		■	■	■	■		■	■	■	■				■	■	■	■		■		■	■	■	■	■
Community: Healthy Beliefs and Clear Standards					■		■	■				■	■	■	■	■	■			■	■	■			■
Family: Bonding (opportunity, skills, and recognition)									■			■					■								
Family: Healthy Beliefs and Clear Standards									■								■								
Peer: Bonding (opportunity, skills, and recognition)											■	■		■			■					■	■	■	■
Peer: Healthy Beliefs and Clear Standards													■	■			■				■				
School: Bonding (opportunity, skills, and recognition)																	■								
School: Healthy Beliefs and Clear Standards																	■								

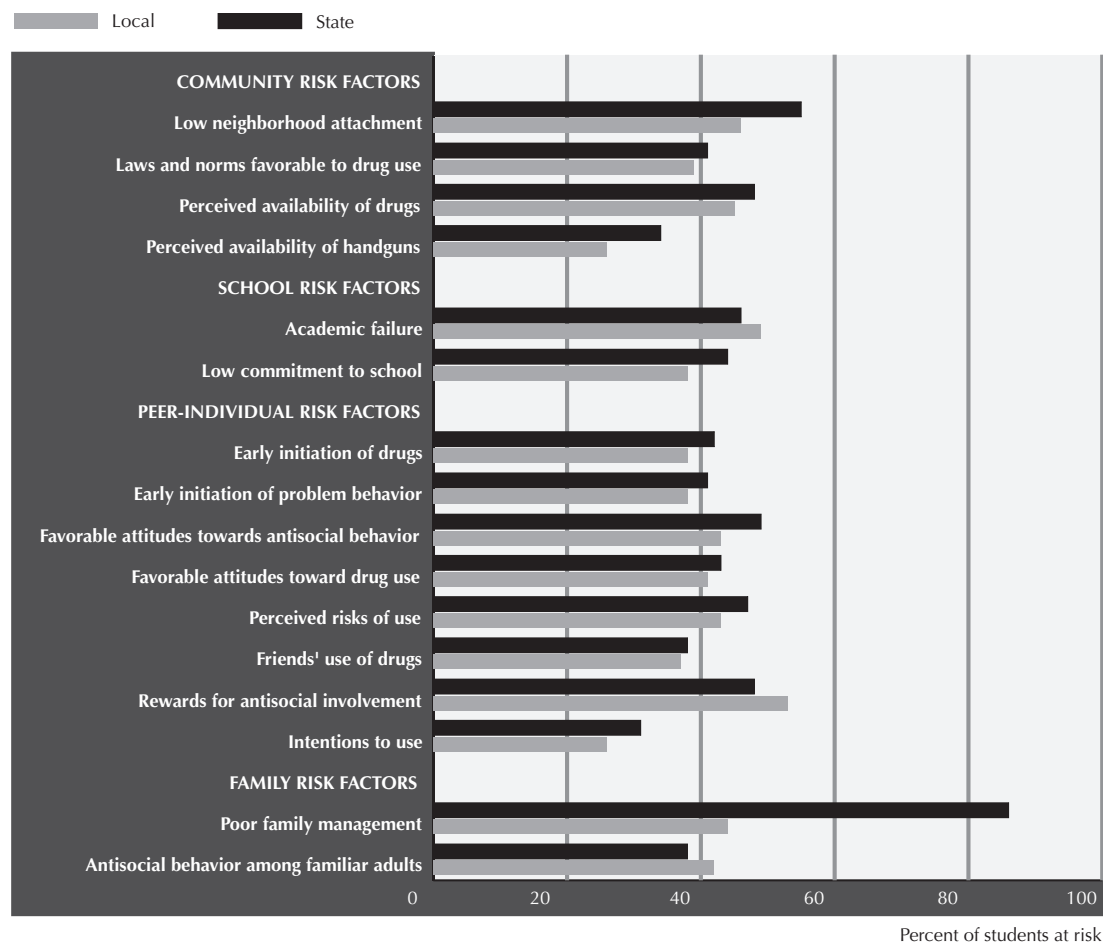
Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.

Using Data to Inform County Prevention Planning



In order to make wise decisions about the use of prevention resources, counties rely on having access to sound data, both about their own communities, and how they compare to demographically similar counties and the state as a whole. One source of such data is the Healthy Youth Survey. Counties are presented with data regarding the percentage of youth at risk or protected in each of the risk/protective factor categories.

Below is an example of a chart of risk factor results that a county might receive.

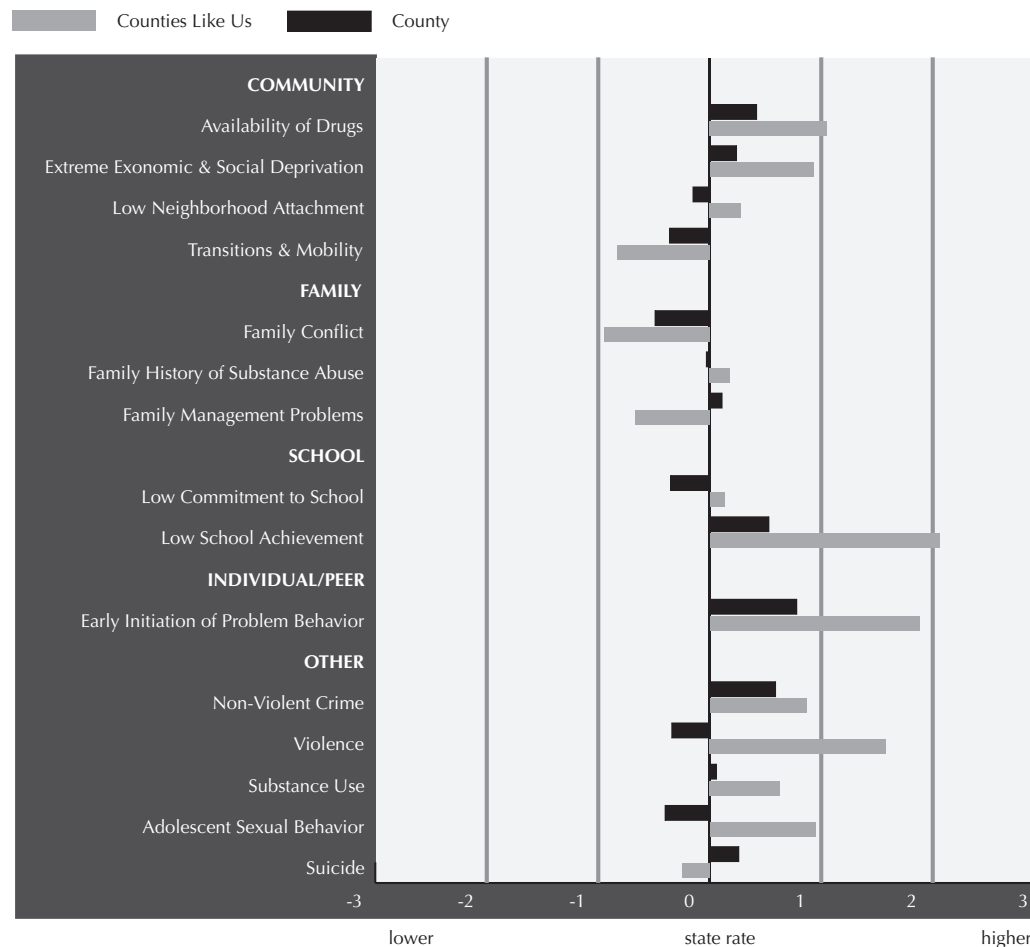




Using Data to Inform County Prevention Planning

In order to make wise decisions about the use of prevention resources, counties rely on having access to sound data, both about their own communities, and how they compare to demographically similar counties, and to the state as a whole. Counties are presented with archival data related to risk factors in their communities. Various archival data sources are utilized to derive a summary measure profile

Below is an example of a chart displaying archival summary measure profile data that a county might receive.





Using Prevention Science

Most participants enrolled in prevention programs funded by the Division of Alcohol and Substance Abuse (DASA) receive services proven to be effective in reducing substance use and other problem behaviors. DASA stresses the use of strategies scientifically proven to reduce substance abuse, while at the same time recognizing the importance of local innovation to develop programs for specific populations or emerging problems.

Best Practices

Best practices are those strategies, activities, or approaches that have been shown through substantial research and evaluation to be effective at preventing and/or delaying substance abuse. DASA utilizes best practices listed by the Center for Substance Abuse Prevention, Western Center for the Application of Prevention Technologies. This list includes programs deemed research-based by scientists and researchers at: National Institute of Drug Abuse; Center for Substance Abuse Prevention; National Center for the Advancement of Prevention; Office of Juvenile Justice and Delinquency Prevention; and the federal Centers for Disease Control and Prevention.

Promising Practices

Promising practices are programs and strategies that have some quantitative data indicating positive outcomes in delaying substance abuse over a period of time, but do not have enough research or replication to support generalizable outcomes.

Innovation

Innovative programs and strategies are developed locally to address a specific need or issue. Development is guided by proven principles of effectiveness. These programs have generally not undergone the rigorous scientific review of a best practice.

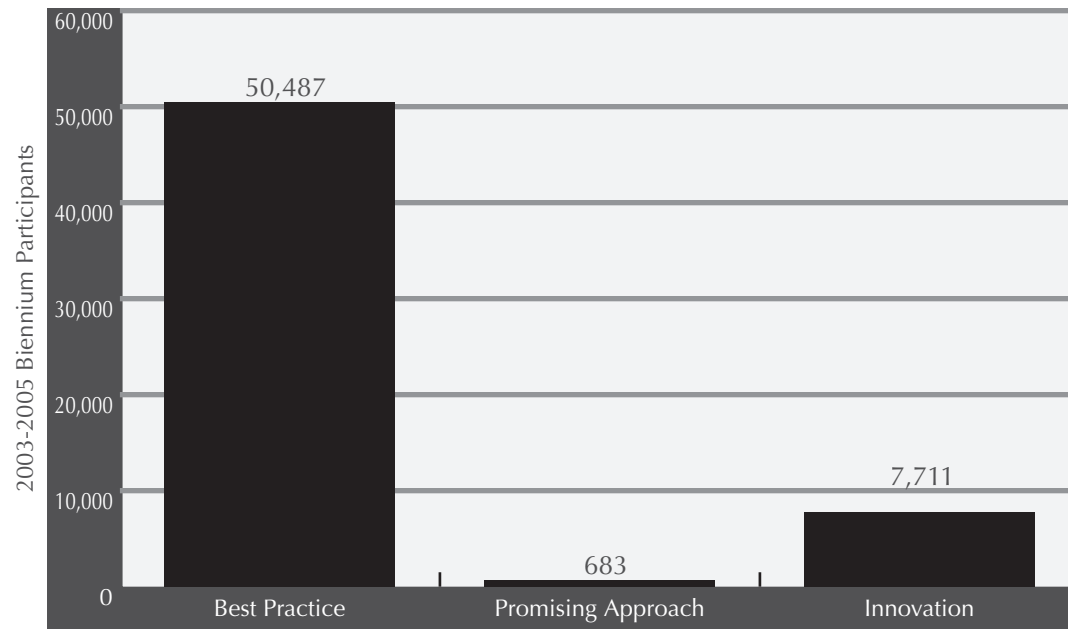
Guiding Principles

Guiding principles are recommendations on how to create effective prevention programs. When a community already has a prevention program or strategy in place, the guiding principles can be used to gauge the program's potential effectiveness. They can also be used to design an innovative program/strategy when none of the best practices are appropriate to the community's needs.

DASA requires 50% of county prevention programs to utilize best or promising practices. All DASA-funded prevention programs must adhere to the guiding principles to ensure effective implementation. In the 2003-2005 Biennium, 70% of DASA-funded prevention programs represent best or promising practices, exceeding the 50% requirement.



The Majority of Participants in DASA-Funded Prevention Programs are in Programs Using Best Practices.



Source: Washington State Performance-Based Prevention System.

The Division of Alcohol and Substance Abuse stresses the use of proven strategies to reduce substance abuse, while recognizing the importance of local innovation to develop programs for specific population or emerging problems. Best practices are strategies, activities, or approaches which have been shown scientifically to prevent and/or delay substance abuse. Promising approaches have some quantitative data demonstrating positive outcomes, but not enough research or replication to support generalizable outcomes. Innovative programs or strategies are developed locally to address a specific need or issue.

DASA Prevention Programs Save the State Money



Funds spent on prevention services are a sound investment in reducing burdens to the taxpayer. Research conducted by the Washington State Institute for Public Policy (WSIPP) in 2004 provided a cost-benefit analysis of prevention programs.¹ Prevention programs save money through reduced costs associated with drug addiction, criminal justice, and health care. These cost savings are realized over the life of the participant. By selecting programs with proven research behind them, prevention providers funded by the Division of Alcohol and Substance Abuse save Washington State taxpayers millions of dollars.

Using the results from the WSIPP study, and based on the number of program recipients, the chart below indicates the level of savings achieved as a result of 11 research-based programs implemented in the 2003-2005 Biennium:

Program Name	Net Cost Benefit per Participant ¹	# of DASA Participants ²	Total Cost Benefit ²
All Stars	\$120	375	\$45,000
Guiding Good Choices/Preparing for the Drug Free Years	\$6,918	374	\$2,587,332
Life Skills Training Program	\$717	6,625	\$4,750,125
Mentoring: Big Brothers/Big Sisters	\$2,822	666	\$1,879,452
Parents as Teachers	\$800	26	\$20,800
Project ALERT	\$54	5,729	\$309,366
Project Northland	\$1,423	398	\$566,354
Project SUCCESS (OSPI)	\$485	28,522	\$13,833,170
Project Towards No Drug Abuse	\$274	425	\$116,450
SMART leaders	\$485	59	\$28,615
Strengthening Families Program	\$5,805	1,827	\$10,605,735

¹Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, WA: Washington State Institute for Public Policy, 2004.

²Washington State Division of Alcohol and Substance Abuse Performance-Based Prevention System.



Statewide Prevention Services and Programs

The Division of Alcohol and Substance Abuse (DASA) funds statewide services primarily by way of interagency agreements and partnerships with state agencies and non-profit organizations. The following programs are either partially or fully funded by DASA:

School-Based Prevention and Intervention Services Program

The Office of Superintendent of Public Instruction (OSPI) administers a school-based program targeting students at risk for developing alcohol, tobacco, and other drug-related problems. During the 2003-2005 Biennium, more than 300 Prevention/Intervention Specialists implemented programs in ten Educational Service Districts and three school districts. These services were offered in all the regions of the state and were delivered to over 28,000 kindergarten through twelfth grade students.

Healthy Youth Survey

OSPI administers an adolescent health behavior survey every other year. Substance abuse prevalence and risk/protective factor data are generated from this survey and used by prevention planners and service providers throughout our state. The 2004 Healthy Youth Survey was the eighth time health-related attitudes and behaviors of Washington's public school students have been assessed. More than 185,000 students in elementary, middle, and high schools across the state participated in the survey.

Reducing Underage Drinking Initiative (RUaD)

RUaD's goal is to prevent or reduce the consumption of alcohol by minors, especially through increased enforcement of underage drinking laws. The RUaD program has received block grant awards totaling \$2,866,000 since 1998 from the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP). The block grants have supported public education efforts, Liquor Control Board enhancements, a RUaD track and/or workshops at the State Prevention Summit, youth leadership activities, and community-based coalitions. In addition to the block grants, DASA is the recipient of three discretionary grants of nearly \$1,850,000. These funds support the efforts of five communities as they implement comprehensive approaches to the problem of underage drinking, with an emphasis on increasing law enforcement activity. Washington Traffic Safety Commission and the Washington State Liquor Control Board are primary partners in RUaD. Other collaborators include: local law enforcement, Mothers Against Drunk Driving, the statewide College Coalition for Substance Abuse Prevention, and other state agencies.

Reducing Access to Tobacco Products (Synar Regulation)

The Substance Abuse Prevention and Treatment (SAPT) block grant requires that states focus on reducing youth access to tobacco products through retail outlets. The Synar Regulation requires that states reach and maintain a maximum 20% non-compliance rate as measured through compliance checks. Washington has always been in compliance with the Synar regulation. Washington's Synar success is due to DASA's positive and effective relationship with two other state agencies,



the Department of Health (DOH) and the Liquor Control Board. DOH develops a randomized list of tobacco retailers in the state and then asks local health jurisdictions to implement youth access compliance checks. Local health jurisdictions are responsible for implementing the Synar compliance checks assigned to them through the statewide sampling. They report the results of the checks back to DOH. In 2004, the non-compliance rate was 10.1%.

College Coalition for Substance Abuse Prevention

The University of Washington facilitates the College Coalition for Substance Abuse Prevention. Coalition members administer campus-based prevention services targeting students and university communities. The College Coalition was established to provide the development, implementation, and continuation of substance abuse prevention programming at all college and university campuses in Washington State. The coalition meets six times during the academic year on different campuses throughout the state. During the 2003-2005 Biennium, the Coalition sponsored a survey of college and university student alcohol and other drug use.

Children's Transition Initiative (CTI)

DASA established the Children's Transition Initiative (CTI) to encourage prevention providers to address the risk and protective factors in children transitioning from grade school to middle school. CTI requires enrollment of children and their families for a minimum of 10 months, and the utilization of research-based prevention strategies. CTI counties include Benton, Columbia, Ferry, Franklin, Grant, Island, Lincoln, Spokane, and Whatcom.

Alcohol/Drug Clearinghouse

DASA funds the Alcohol/Drug Clearinghouse to provide a wide variety of timely resource materials and information on substance abuse. Materials and information are accessible to Washington State residents, including non-English-speaking individuals and persons with disabilities. The Clearinghouse maintains a statewide toll-free phone number for requesting resources, including a system for receiving requests by telephone from the hearing-impaired community, a website for requesting materials, and a video lending library. Requests for information or materials are usually processed within 24 hours. The Clearinghouse also maintains an electronic newsletter to communicate federal, state, and local prevention news and activities/campaigns to individuals and organizations in Washington State. During the 2003-2005 Biennium, the Clearinghouse distributed over 900,000 resource items, and made resources available to over 200 community and school-based events.



Exemplary Substance Abuse Prevention Awards

The Washington State Exemplary Substance Abuse Prevention Awards Program recognizes outstanding substance abuse prevention programs, including individuals working in the prevention field, and media organizations that support prevention efforts. A review committee evaluates the nominations and approves those meeting the selection criteria. Members of the committee also nominate and select additional awardees for their special contributions to the field. The state awards process is designed to coordinate with the existing national awards process, with the goal of identifying Washington State Exemplary Programs that could be encouraged to apply at the national level. The awards process is conducted in cooperation with the Governor's Prevention Advisory Committee, the Lieutenant Governor's Office, the Citizens Advisory Council on Alcoholism and Drug Addiction, and the Washington Interagency Network.

Community Prevention Capacity Building

Until the start of the 2003-2005 Biennium, the Community Prevention Training System provided financial support to counties and tribes for capacity building. Now each county has a set amount of funding specifically earmarked for training. It may choose to improve its own abilities to plan and develop programming, or support community members whose participation in training would fill an identified need.

Communication and Media Program

DASA's Communication and Media Program provides materials and technical assistance to communities in Washington State to increase public awareness about the prevention and treatment of alcohol and other drug misuse and dependency. In addition, DASA manages and supports Partnership for a Drug Free Washington (PDFW), a statewide, ongoing media campaign allied with the Partnership for a Drug-Free America. Support for PDFW includes 30 media and corporate partners statewide who have contributed over \$2 million in airtime and print advertising.

Through partnerships with corporations, state and community agencies, and advertising and news media, DASA educates the public about the health, social and economic impacts of drug misuse and dependency; alcohol and other drug prevalence and trends; risk and protective factors; media literacy; effective ways to prevent and reduce misuse; and how to access prevention and treatment resources. Messages and campaigns are tailored for professionals, educators, parents, teens, youth, and older adults. Materials are available in English, Spanish, Russian, and Asian languages.

Solutions: Substance Abuse Prevention & Treatment

SOLUTIONS

Prevention

Treatment



Introduction

Individuals are eligible for DASA-funded services if they are low-income (generally below 200% of the Federal Poverty Level) or indigent, and are assessed as chemically dependent. For persons applying for treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), eligibility is further restricted to those who are unemployable as a result of their alcohol or other drug addiction. In the 2005-2007 Biennium, treatment services are expanded to include those who have primary Medicaid eligibility (those receiving General Assistance-Unemployable, General Assistance-Expedited, Supplemental Security Income, and Temporary Assistance to Needy Families). Treatment services are designed to maintain a cost-effective, quality continuum of care for rehabilitating alcoholics and drug addicts.

Contracted treatment and support services include:

- Diagnostic evaluation
- Alcohol/Drug detoxification
- Outpatient treatment
- Opiate substitution (methadone) treatment
- Intensive inpatient treatment
- Recovery house
- Long-term residential treatment
- Involuntary treatment/civil commitment for individuals with alcohol/drug addiction
- Youth residential treatment
- Youth outpatient treatment
- Residential treatment for pregnant and parenting women (with therapeutic childcare)
- Outpatient treatment for pregnant and parenting women (with childcare)
- Treatment for co-occurring disorders
- Tribal treatment programs
- Monolingual programs for non-English speakers
- Treatment program for the deaf/hard of hearing
- Urine screening
- Brief interventions and referral from emergency departments
- Support services for those accessing treatment and recovery services
- Alcohol and Drug 24-Hour Help Line



Specialized contracted support services for eligible individuals include:

- Child care
- Translation services (including interpreters for persons who are deaf or hard of hearing)
- Transportation assistance
- Integrated crisis response/secure detoxification services
- Case management
- Youth outreach
- Cooperative housing (Oxford House) and other transitional housing support

State and federal funding requirements give priority for treatment and intervention services to the following:

- Pregnant and postpartum women and families with children
- Families receiving Temporary Assistance for Needy Families (TANF)
- Child Protective Services referrals
- Youth
- Injection drug users (IDUs)
- People with HIV/AIDS



DASA Treatment Philosophy for Alcohol, Tobacco, and Other Drug Addiction

DASA's program of substance abuse services is based on knowledge gained from medical research that alcoholism and addiction to other drugs is a progressive disease. Research and evaluation studies cited throughout this report indicate that long periods of sobriety, abstinence, and/or reduced drug use result from effective intervention and treatment. Research also demonstrates that treatment results in a marked reduction in negative consequences for the addicts, their families, friends, and society at large, as measured by domestic violence, disrupted families, employment histories, and public costs for law enforcement and the courts, welfare dependence, medical and hospital costs, and admissions to psychiatric hospitals.¹ As alcoholism and addiction are chronic, relapsing disorders, continued treatment and support services may be required after any initial course of treatment.

Alcohol, tobacco, or other drug addiction is an individual, family, worksite, and community affliction. These addictions negatively impact all sectors of society regardless of age, education, race/ethnicity, gender, occupation, or socio-economic status. Therefore, it is critical that all citizens – especially teachers, employers, parents, and youth – understand the illness is treatable and the channels for getting a person into private or public treatment agencies. DASA's philosophy recognizes the importance of ensuring all treatment agencies meet established standards for providing services. Treatment must be tailored to the specific needs of each individual, and a continuum of treatment services is essential for matching clients with the optimal types and sequences of treatments. It is also important that specialized treatment services be available for populations with special needs and circumstances, such as adolescents, pregnant and parenting women (and their children), members of minority populations, and those with disabilities.

DASA recognizes that substance abuse treatment cannot occur in isolation from law enforcement and public safety, educational institutions, and social, health, and economic services. It is essential that substance abuse treatment have linkages with all segments of society that are important to recovery and rehabilitation.

A key aspect of DASA's philosophy is recognizing the generational loop of addiction. It is important to break the generational cycle of addiction by promoting alcohol, tobacco, and other drug prevention programs, enrolling children of addicts in appropriate prevention activities, and providing early intervention services when needed.

¹See, for example: Wickizer, T., and Longhi, D., *Economic Benefits and Costs Associated with Substance Abuse Treatment Provided to Indigent Clients through the Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Service, Division of Alcohol and Substance Abuse, 1997. See also: Schrager, L. Joyce, J., and Cawthon, L. *Substance Abuse, Treatment, and Birth Outcomes for Pregnant and Postpartum Women in Washington State*. Olympia, WA: Washington State Department of Social and Health Services, Planning, Research & Development and Office of Research & Data Analysis, 1995.



Substance Use and Current Need for Treatment

Based on the *2003 Washington State Needs Assessment Survey* conducted by the Department of Social and Health Services' Research and Data Analysis Division, 10.9% of the Washington State adult population (age 18 and older) living in households were estimated to be in need of substance abuse treatment in 2003.¹ Treatment need for adolescents (ages 12 to 17) living in households is estimated at 8.7%. (The definition of need for treatment is provided on the following page.)

Alcohol is by far the most used substance in Washington State, and the one for which there is the highest rate of treatment need.

Use rates among adults living in households for individual substances were as follows:

	Lifetime Use	Past 12-Month Use	Past 30-Day Use
Alcohol	88.0%	72.9%	57.9%
Any Illicit Drug	45.2%	9.6%	5.6%
Marijuana	42.2%	7.4%	4.3%
Stimulants*	14.5%	0.5%	0.1%
Cocaine	15.8%	1.1%	0.9%
Opiates**	8.7%	2.0%	0.9%
Heroin	1.7%	0.1%	0.0%

* Includes amphetamine, methamphetamine, and other stimulants.

** Other than heroin.

¹ *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.



Current Need for Treatment Among Population Subgroups in Washington State

Based on data from the 2003 Washington State Needs Assessment Household Survey conducted by the Department of Social and Health Services' Research and Data Analysis Division, the current estimated need for treatment varies widely across population subgroups:

- Compared with the overall treatment need rate of 10.9% of adults living in households, some subgroups have lower rates of treatment need. These include: those ages 45-64 (7.8%) and 65+ (1.8%); females (7.3%); African-Americans (10.4%) and Asians (4.9%); those who are married (5.9%); and college graduates (8.1%).
- Other subgroups have higher estimated needs for treatment. These include: (those ages 18-24 (22.6%) and 25-44 (13.0%); males (14.7%); American Indians (15.8%) and multi-race individuals (16.2%); and those never married (21.0%).

Need for chemical dependency treatment is associated with income. Adults living in households with incomes above 200% of the Federal Poverty Level (FPL) have lower rates of treatment need (10.0%) than do adults living in households with incomes below 200% FPL (13.6%).

Those classified as in need of chemical dependency treatment in the past year met one or more of the following conditions.

1. Reported life DSM-IV* alcohol or drug abuse or dependence symptoms, reported at least one symptom in the past 12 months, and used alcohol or drugs in the past 12 months.
2. Received professional alcohol or drug treatment (excluding detoxification) during the past 12 months.
3. Reported having a problem with alcohol or drugs and were using alcohol or drugs regularly during the past 12 months. Regular alcohol use is defined as having three or more drinks at least one day per week. Regular drug use is defined as using marijuana 34 or more times in the past 12 months or as using other illicit drugs eight or more times in the past 12 months.
4. Reported heavy use of drugs or alcohol in the past 12 months. Heavy alcohol use is defined as four or more drinks per drinking day, three or more days per week during the past 12 months. Heavy drug use is defined as using any illicit substance 34 or more times during the past 12 months.

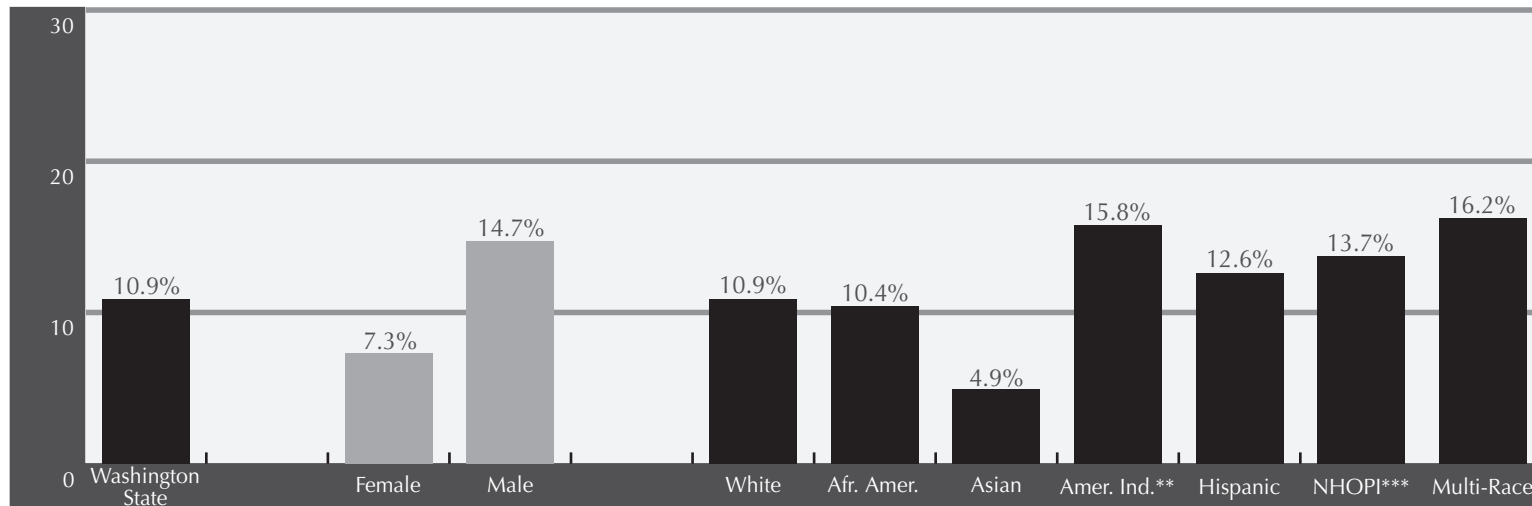
*DSM-IV is the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association in 1994. It contains diagnostic criteria for the most common mental disorders, and includes findings on description, diagnosis, treatment, and research.



More than One Out of Ten Washington State Adult Residents is in Need of Chemical Dependency Treatment.*

Current Need for Treatment

Percent of Adults in Households



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

* For definition of Current Need for Treatment, see page 176.

** American Indian Includes Alaskan Natives.

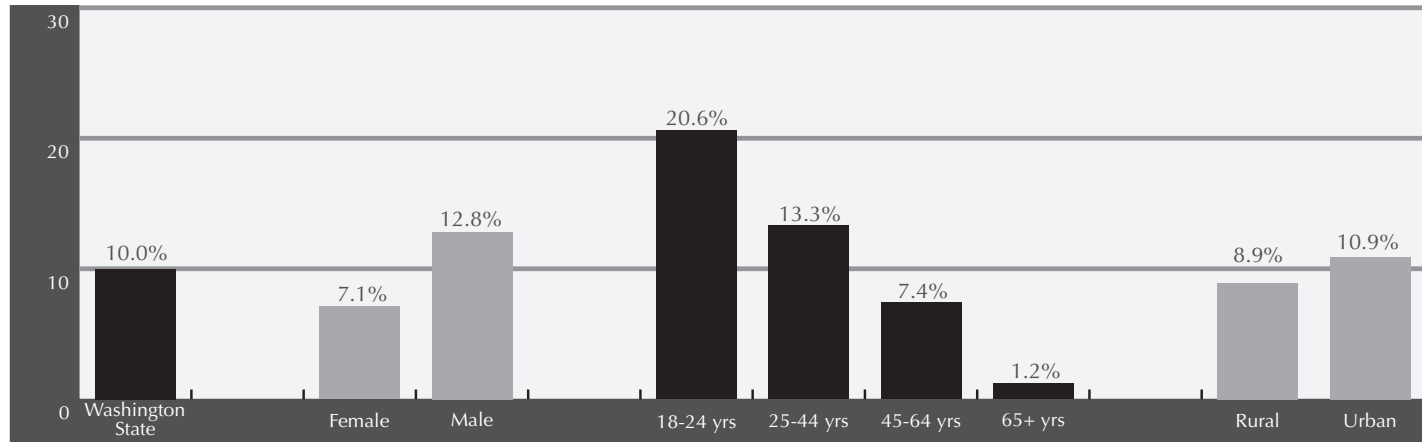
*** Native Hawaiian or Pacific Islander.

Younger Adults (Ages 18-24), Males, and Urban Residents Have Higher Rates of Need for Chemical Dependency Treatment.*



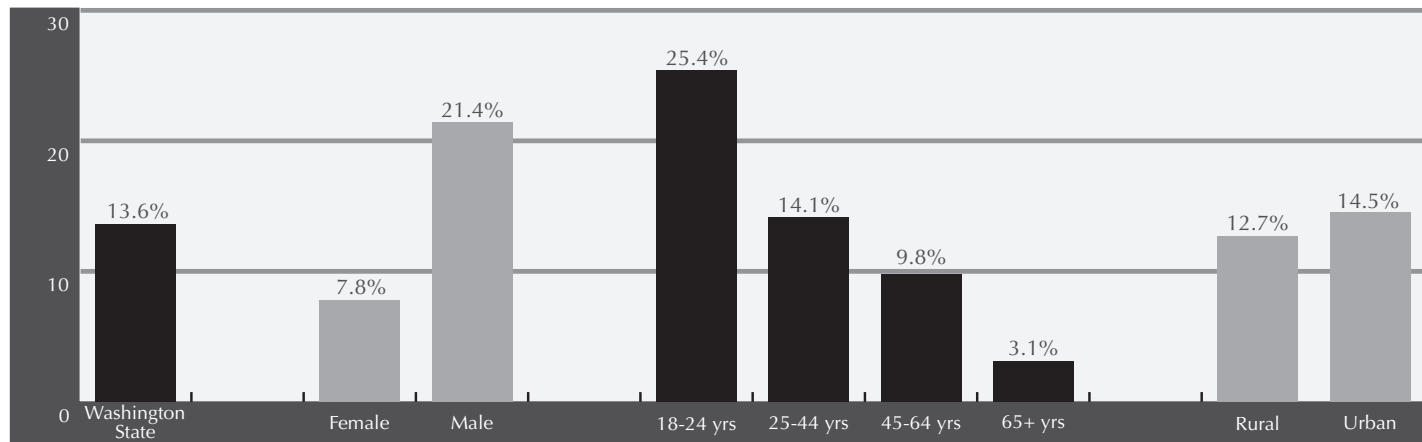
Current Need for Treatment Among Adults Above 200% of Federal Poverty Level

Percent of Adults in Household



Current Need for Treatment Among Adults at or Below 200% of Federal Poverty Level

Percent of Adults in Household



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

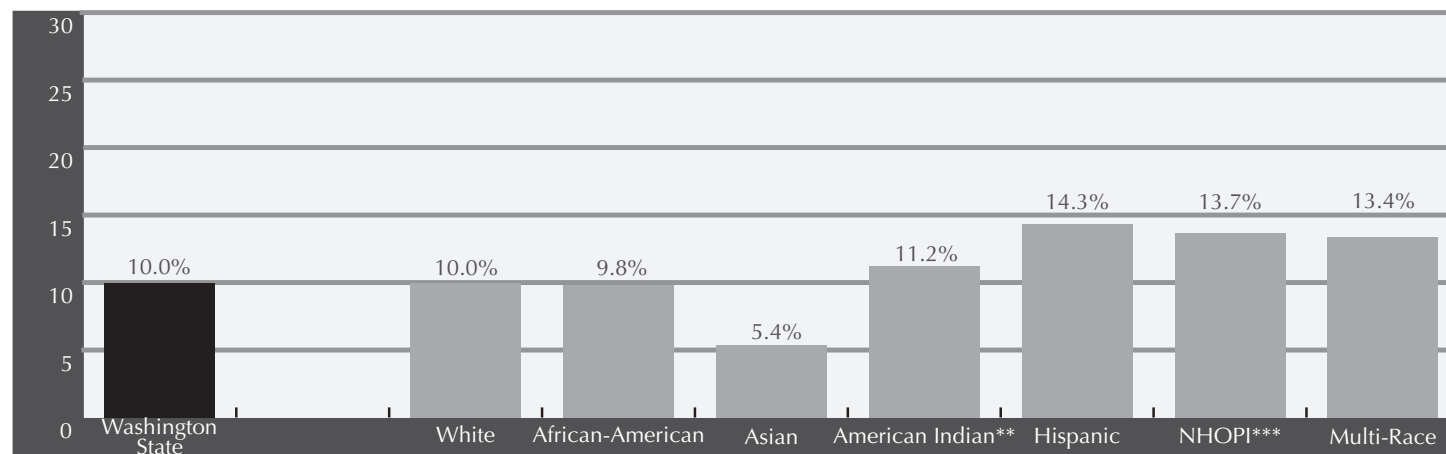
* For definition of Current Need for Treatment, see page 176.



White, American Indian, and Multi-Race Washington State Adult Residents Have Higher Rates of Chemical Dependency Treatment Need.*

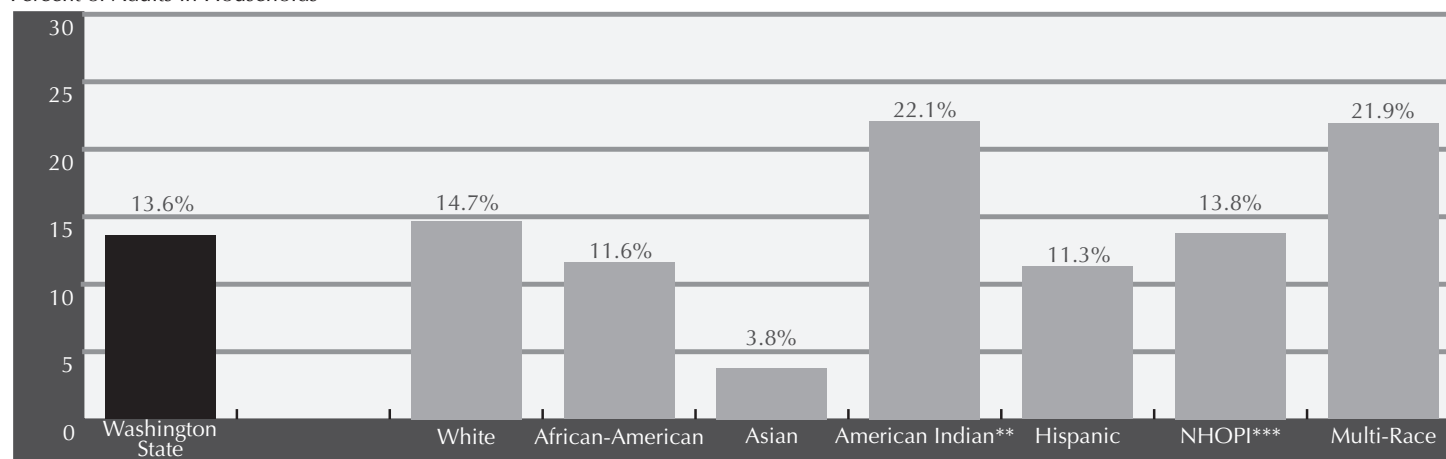
Current Need for Treatment for Adults Above 200% of the Federal Poverty Level

Percent of Adults in Households



Current Need for Treatment for Adults at or Below 200% of the Federal Poverty Level

Percent of Adults in Households



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

*For definition of Current Need for Treatment, see page 176.

**American Indian includes Alaskan Natives.

***Native Hawaiian or Pacific Islander.

Computing the DASA Treatment Gap



The Treatment Gap rate is a measure over a given period of time of those who qualify – both clinically and financially – for Division of Alcohol and Substance Abuse (DASA)-funded treatment services but who, because of the limits of available funding, do not receive it. To compute the treatment gap, an estimate is established of all those at or below 200% of the Federal Poverty Level (FPL) and in need of treatment. Those with private insurance, access to military health services, or who are enrolled in the subsidized portion of the Washington Basic Health Plan (BHP) are subtracted from this number, as these individuals would be expected to access chemical dependency treatment services without use of DASA funds.

The following equation is then used to compute the DASA Treatment Gap:

$$\text{DASA Treatment Gap Rate} = \frac{\text{\# of county residents qualifying for and requiring DASA-funded treatment minus those receiving it}}{\text{\# of county residents qualifying for and requiring DASA-funded treatment}} \times 100$$

The statewide treatment gap is computed by aggregating the county numbers and using the same formula. Counts of persons receiving DASA-funded treatment are drawn from DASA's TARGET system. These counts represent cases that were open in SFY 2003. Individuals must have received at least one residential or outpatient service during this period. Persons receiving more than one treatment service are only counted once.

Only those living in households are included. Those residing in institutions or group care settings are excluded from both the numerator and denominator. Results by county are displayed on page 182.

For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance Abuse. Address and phone number are found on the back cover.



The Treatment Gap

SFY 2003 Treatment Gap Rates in Washington State for Publicly Funded Chemical Dependency Services

Target Population	Needing & Eligible for DASA-Funded Treatment	Received Treatment with DASA-Funded Support	Number of Eligible Individuals Unserved	Treatment Gap Rate (Unserved Need)
Adults w/children < 18	34,389	10,554	23,835	69.3%
Adults w/o children under 18	61,807	14,785	47,022	76.1%
ALL ADULTS 18 AND OLDER	96,196	25,339	70,857	73.7%
ADOLESCENTS (AGES 12 - 17)	18,930	5,875	13,055	69.0%
TOTAL	115,126	31,214	83,912	72.9%

Estimates exclude detox, transitional housing, and Department of Corrections. Also excluded are adults who have private, Washington Basic Health Plan, or military health insurance. An addition adjustment was made to include individuals estimated to be eligible for DASA-funded treatment at some time during the 12-month period.

For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance Abuse. Address and phone are found on the back cover.

Statewide, in SFY 2003, 76.3% of Adults in Household Who Qualified for and were in Need of DASA-Funded Chemical Dependency Treatment Did Not Receive It.*



County	Percent of Adults <200% FPL & in need of Treatment	Number of Adults <200% FPL Receiving Treatment	Number of Adults Not Receiving Treatment	Penetration Rate	Treatment Gap	Treatment Gap Rates
Adams	12.0%	67	289	18.8%	81.2%	Whitman 93.6
Asotin	14.4%	178	209	46.0%	54.0%	Kittitas 84.7
Benton	13.7%	687	1,114	38.1%	61.9%	Adams 81.2
Chelan	12.6%	461	544	45.9%	54.1%	Spokane 79.5
Clallam	13.4%	634	606	51.1%	48.9%	King 78.8
Clark	14.1%	1,173	3,180	26.9%	73.1%	Douglas 77.5
Columbia	12.2%	56	**	**	**	Stevens 76.3
Cowlitz	14.0%	824	960	46.2%	53.8%	Whatcom 76.3
Douglas	12.3%	128	441	22.5%	77.5%	Grant 75.7
Ferry	16.7%	102	169	37.6%	62.4%	Klickitat 75.6
Franklin	11.7%	351	746	32.0%	68.0%	Columbia 73.1
Garfield	12.9%	20	**	**	**	Pierce 70.5
Grant	13.0%	462	1,443	24.3%	75.7%	Lewis 70.5
Grays Harbor	13.3%	469	917	33.8%	66.2%	Jefferson 70.3
Island	13.8%	275	415	39.8%	60.2%	Thurston 70.2
Jefferson	12.8%	154	365	29.7%	70.3%	Snohomish 68.7
King	13.6%	5,013	18,591	21.2%	78.8%	Walla Walla 68.1
Kitsap	14.2%	1,071	2,248	32.3%	67.7%	Franklin 68.0
Kittitas	20.4%	209	1,154	15.3%	84.7%	Lincoln 67.7
Klickitat	13.9%	110	340	24.4%	75.6%	Klitsap 67.7
Lewis	13.5%	443	1,058	29.5%	70.5%	Grays Harbor 66.2
Lincoln	12.3%	47	98	32.3%	67.7%	Mason 62.9
Mason	14.2%	330	561	37.1%	62.9%	Ferry 62.4
Okanogan	13.8%	467	698	40.1%	59.9%	Benton 61.9
Pacific	12.0%	225	223	50.3%	49.7%	Island 60.2
Pend Oreille	13.4%	115	157	42.3%	57.7%	Okanogan 59.9
Pierce	13.7%	3,123	7,470	29.5%	70.5%	Skagit 59.6
San Juan	13.2%	112	149	43.0%	57.0%	Pend Oreille 57.7
Skagit	12.8%	686	1,011	40.4%	59.6%	San Juan 57.0
Skamania	13.8%	79	92	46.2%	53.8%	Yakima 56.5
Snohomish	13.1%	2,339	5,128	31.3%	68.7%	Chelan 54.1
Spokane	16.0%	1,848	7,164	20.5%	79.5%	Asotin 54.0
Stevens	14.2%	218	718	23.3%	76.7%	Cowlitz 53.8
Thurston	15.5%	912	2,143	29.8%	70.2%	Skamania 53.7
Wahkiakum	15.6%	39	**	**	**	Pacific 49.7
Walla Walla	15.0%	360	769	31.9%	68.1%	Clark 48.9
Whatcom	18.4%	1,011	3,255	23.7%	76.3%	Columbia **
Whitman	22.9%	110	1,620	6.4%	93.6%	Garfield **
Yakima	12.1%	2,060	2,678	43.5%	56.5%	Wahkiakum **

*Estimates exclude adults who have private, Washington Basic Health Plan, or military health insurance. An addition adjustment was made to include individuals estimated to be eligible for DASA-funded treatment at some time during the 12-month period.

**Treatment penetrations rates suppressed for counties with 60 or fewer adults estimated to need and be eligible for DASA-funded treatment.

For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance Abuse. Address and phone are found on the back cover.



Estimates of Substance Abuse and Treatment Need in Washington State, 2003

	Adult Household Residents		Adults in Households At or Below 200% of Federal Poverty Level	
	# of Residents	% of Residents	# of Residents	% of Residents
NEED FOR TREATMENT				
Current Need for Substance Treatment	478,846	10.9%	144,278	13.6%
ALCOHOL OR DRUG DISORDER				
Lifetime Alcohol or Drug Use Disorder	901,068	20.5%	217,602	20.5%
Past 12-Month Alcohol or Drug Use Disorder	342,325	7.8%	98,909	9.3%
ALCOHOL USE				
Lifetime Use of Alcohol	3,870,608	88.0%	817,738	77.2%
Past 12-Month Use of Alcohol	3,208,952	72.9%	618,413	58.4%
Past 30-Day Use of Alcohol	2,547,638	57.9%	440,971	41.6%
ALCOHOL DISORDER				
Lifetime Alcohol Use Disorder	751,246	17.1%	167,513	15.8%
Past 12-Month Alcohol Use Disorder	308,748	7.0%	81,442	7.7%
USE OF ANY DRUG				
Lifetime Use of Any Illicit Drug	1,988,655	45.2%	442,567	41.8%
Past 12-Month	424,263	9.6%	134,929	12.7%
Past 30-Day Use of Any Illicit Drug	247,818	5.6%	79,743	7.5%
MARIJUANA USE				
Lifetime Use of Marijuana	1,855,293	42.2%	406,257	38.4%
Past 12-Month Use of Marijuana	325,443	7.4%	101,464	9.6%
Past 30-Day Use of Marijuana	190,820	4.3%	62,007	5.9%
STIMULANT USE				
Lifetime Use of Stimulants	636,177	14.5%	154,148	14.6%
Past 12-Month Use of Stimulants	22,359	0.5%	12,497	1.2%
Past 30-Day Use of Stimulants	6,061	0.1%	4,725	0.4%
COCAINE USE				
Lifetime Use of Cocaine	693,276	15.8%	167,526	15.8%
Past 12-Month Use of Cocaine	48,987	1.1%	21,261	2.0%
Past 30-Day Use of Cocaine	15,508	0.4%	6,993	0.7%
DRUG DISORDER				
Lifetime Drug Use Disorder	317,122	7.2%	102,325	9.7%
Past 12-Month Drug Use Disorder	79,552	1.8%	37,107	3.5%

Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2004.

Estimates of Current Need for Substance Abuse Treatment in Washington State, 2003

GROUP	Adult Household Residents			Adults In Household at or below 200% of Federal Poverty Level		
	Population	# Needing Treatment	% Needing Treatment	Population	# Needing Treatment	% Needing Treatment
Total	4,400,316	478,846	10.9%	1,058,918	144,278	13.6%
AGE						
18-24	510,517	115,446	22.6%	217,524	55,193	25.4%
25-44	1,751,416	235,960	13.5%	439,524	62,114	14.1%
45-64	1,497,819	116,099	7.8%	216,555	21,302	9.8%
65+	640,564	11,342	1.8%	185,315	5,670	3.1%
SEX						
Male	2,146,952	315,469	14.7%	461,923	98,974	21.4%
Female	2,253,364	163,376	7.3%	596,994	45,304	7.6%
RACE/ETHNICITY						
White-NH	3,592,265	392,882	10.9%	732,678	106,054	14.7%
Black-NH	121,115	12,637	10.4%	40,917	4,757	11.6%
Asian	246,424	12,000	4.9%	81,624	3,116	3.8%
Amer. Indian*	56,055	8,873	15.8%	23,898	5,273	22.1%
NHOPI**	12,254	1,683	13.7%	4,610	636	13.8%
Multi-Race	104,862	17,010	16.2%	34,716	7,590	21.9%
Hispanic	267,343	33,761	12.6%	149,475	16,853	11.3%
MARITAL						
Married	2,620,202	208,445	8.0%	455,415	44,929	9.9%
Div/Sep	649,928	72,709	11.2%	211,992	23,010	10.9%
Widowed	257,456	10,160	3.9%	104,004	3,765	3.6%
Never Mar	872,730	187,531	21.5%	287,507	72,575	25.2%
EDUCATION						
Not HS Grad	354,637	40,723	11.5%	211,817	23,040	10.9%
HS Graduate	4,045,679	438,123	10.8%	847,101	121,238	14.3%
POVERTY						
Below 200%	1,058,918	144,278	13.6%	1,058,918	144,278	13.6%
Above 200%	3,341,399	334,567	10.0%	-	-	-
*American Indian includes Alaskan Native.						
**Native Hawaiian or Pacific Islander						

Treatment Admission Trends

**Treatment
Admission**

Adult

Youth



Modality categories are defined as follows:

Detoxification

Detoxification is a short-term residential service for individuals withdrawing from the effects of excessive or prolonged alcohol or drug abuse. Services continue only until the person recovers from the transitory effects of acute intoxication. Detoxification always includes supervision and may include counseling and/or medical care and use of pharmacological agents. Some counties provide detoxification in specialized freestanding facilities; in other counties, detoxification is provided in community hospitals.

Intensive Inpatient

Intensive inpatient treatment is a highly structured program for chemically dependent persons in a residential setting. Services emphasize alcohol and drug education and individual and group therapy. The length of stay in intensive inpatient treatment for adults is based on American Society for Addiction Medicine (ASAM) criteria.

Recovery House

Recovery houses provide social, recreational, and occupational therapy as well as treatment in a drug/alcohol-free residential setting. The program emphasizes helping patients re-enter the community and the outpatient phase of treatment.

Long-Term Residential

Long-term residential treatment is a specialized program for chemically dependent persons who require periods of treatment in excess of 90 days. It includes domiciliary care, counseling, and other therapies to patients who reside at the treatment facility.



Other Residential

This category includes transitional housing, residential treatment for co-occurring chemical dependency and mental health disorders, and on-site group care enhancement services for youth.

Transitional housing provides pregnant and parenting women who have completed chemical dependency treatment with up to 18 months of housing. In conjunction with the housing component, women receive case management services that monitor participation in off-site treatment, prepare clients for self-sufficiency, and link women and their children to other needed services.

Co-occurring disorders programs are provided in residential chemical dependency treatment facilities. Utilizing a group care enhancement model, mental health professionals at the facilities provide assessment, education, in-service training for staff, and linkages to mental health providers in the community.

Through group care enhancement contracts, adolescent chemical dependency treatment providers are able to deliver on-site services to children residing in Department of Social and Health Services children's residential facilities. These include select group homes operated by the Division of Children and Family Services, the Mental Health Division, and the Juvenile Rehabilitation Administration. Providers are able to provide individual drug and alcohol assessments; individual, group, and family treatment; prevention and education groups; training of residential agency staff; case planning and consultation, and linkages to other community alcohol and drug services.

Outpatient and Intensive Outpatient Treatment

Outpatient treatment services consist of a variety of diagnostic and treatment services provided according to a prescribed treatment plan in a non-residential setting. Outpatient treatment provided for indigent patients under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) includes vocational counseling and other efforts to help patients regain employment.

Opiate Substitution Treatment

Opiate substitution treatment is an outpatient service for individuals addicted to heroin or other opiates. State-funded and accredited opiate substitution treatment agencies provide counseling and daily or near-daily administration of methadone or other approved substitute drugs.

Treatment Admission Trends

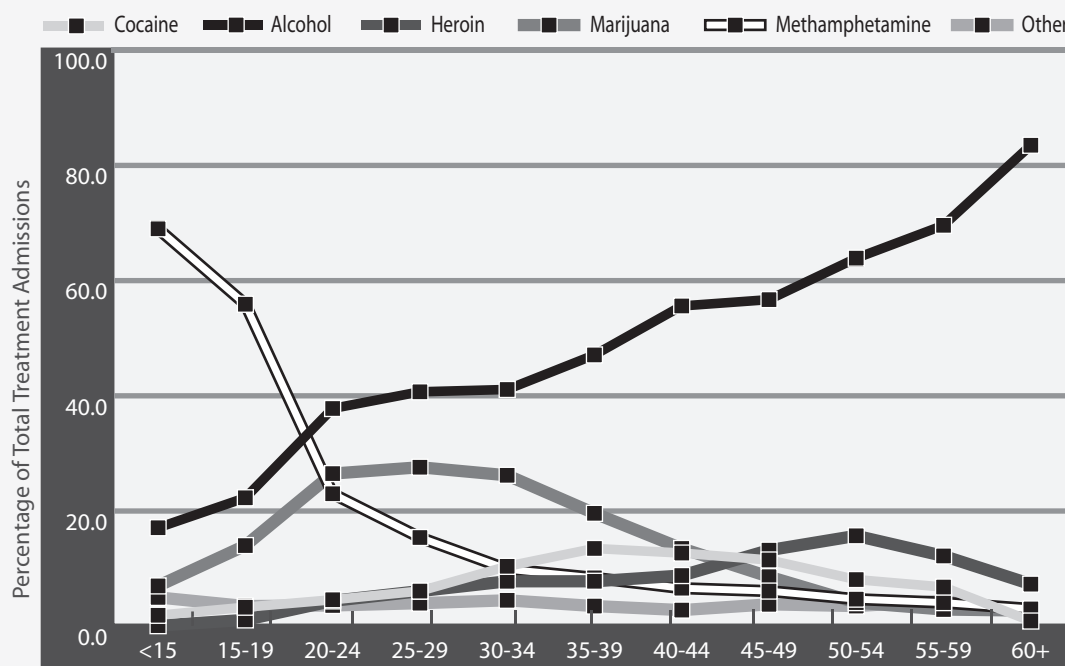
**Treatment
Admission**

Adult

Youth



Primary Drug of Abuse in DASA-Funded Treatment Admissions Varies Significantly By Age.*

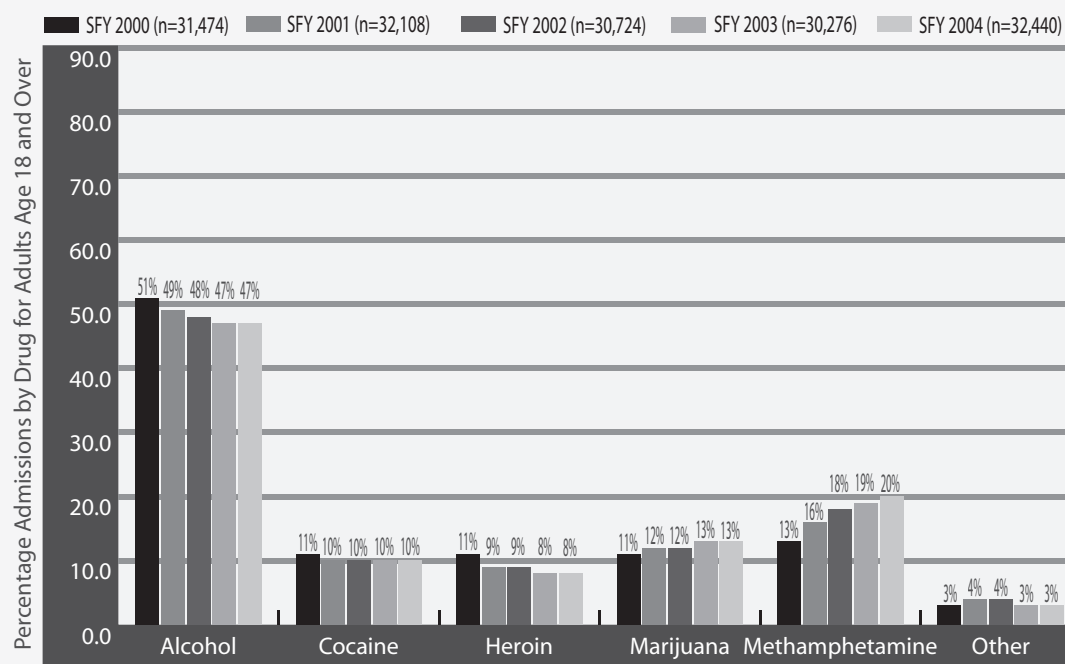


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

Primary drug of abuse upon treatment admissions reflects drug use in the wider population. This graph indicates that DASA-funded admissions by primary drug of abuse vary widely by age cohort. As a percentage of total admissions, treatment admissions for alcohol consistently rise as the population ages. The vast majority of treatment admissions for marijuana occur in the under-25 population. Methamphetamine admissions are highest among individuals in their twenties. Heroin admissions peak among the population in their early fifties.

*Excludes detoxification and transitional housing.

Alcohol is Cited as the Primary Drug of Abuse in the Plurality of Adult Admissions to DASA-Funded Treatment.*



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse Department of Social and Health Services.

This graph indicates that in SFY 2004, alcohol was the primary drug of abuse for a plurality of adult admissions to DASA-funded admissions. Admissions to treatment for methamphetamine abuse continue to rise.

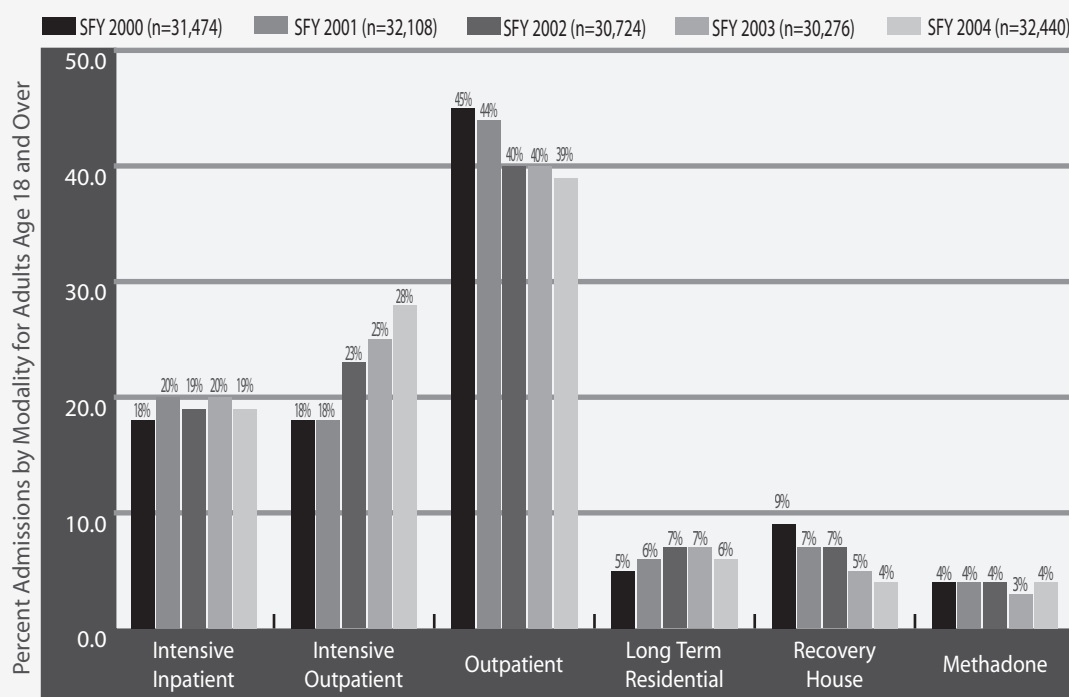
The number of total admissions to DASA-funded treatment has increased. This likely reflects new avenues to access treatment as a result of funding through the Criminal Justice Treatment Account (CJTA).

Note: Data may include multiple admissions for a single individual over the course of a year.

*Excludes detoxification and transitional housing.



Two Thirds of Adult Admissions to DASA-Funded Treatment are for Outpatient and Intensive Outpatient Services.*

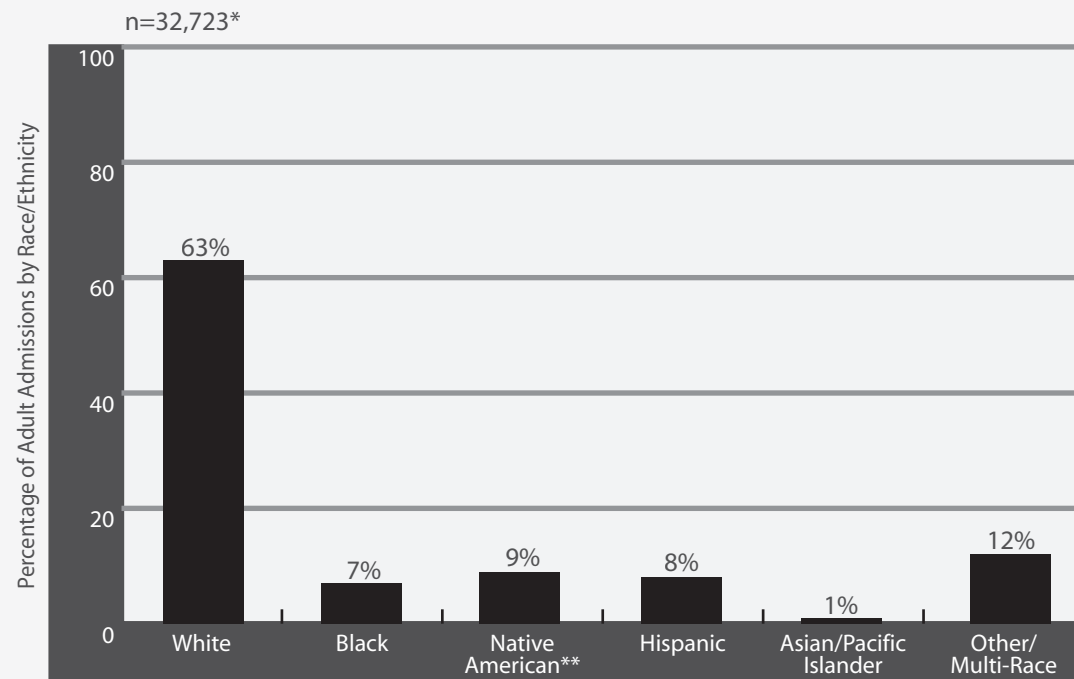


Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that two thirds of adult admissions to DASA-funded chemical dependency treatment are for intensive outpatient and outpatient services. The total number of admissions rose 7.1% in SFY 2004, likely reflecting new avenues for treatment access under the Criminal Justice Treatment Account (CJTA). The number of intensive outpatient admissions has risen 56.2% since SFY 2000 (from 5,733 in SFY 2000 to 8,957 in SFY 2004); during this same period, outpatient admissions declined 11.5% (from 14,119 in SFY 2000 to 12,501 in SFY 2004).

* Excludes detoxification and transitional housing.

Racial and Ethnic Minorities Comprise 37% of Adult Admissions to DASA-Funded Chemical Dependency Treatment Services.



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

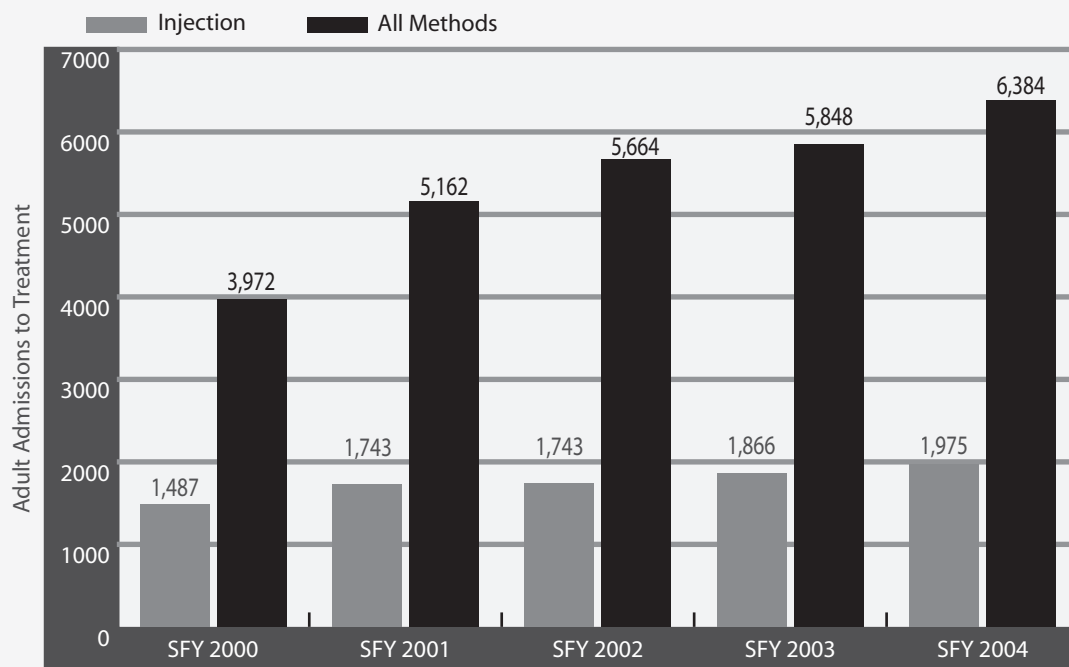
This graph indicates that racial/ethnic minorities comprise approximately 37% of adult admissions to DASA-funded chemical dependency treatment. Percentages of adults from different groups receiving DASA-funded treatment vary across modalities.

* In the U.S. Census, "Hispanic" is listed as an ethnicity, rather than as a racial group. Hence, Hispanic admissions may be duplicated in the racial categories.

** Includes Eskimo/Alaskan Native/Aleut



The Number of Adults Admitted to DASA-Funded Treatment for Methamphetamine Use Continues to Rise.



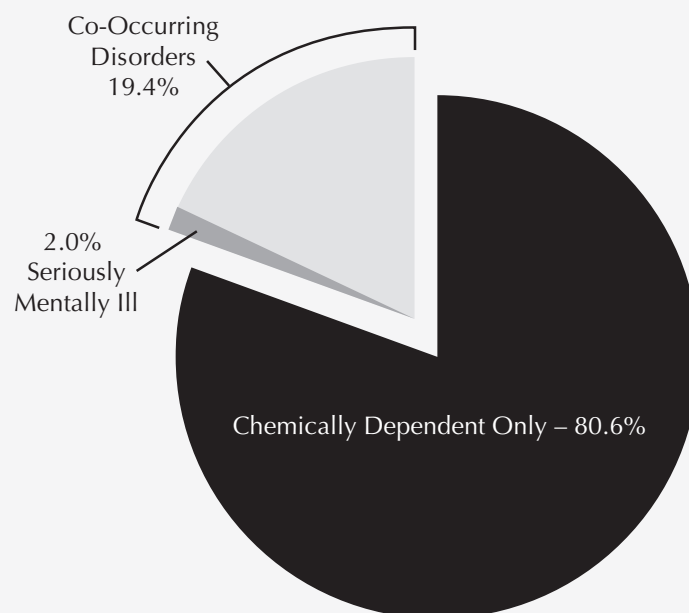
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

The number of adults admitted to DASA-funded treatment for methamphetamine continues to rise. This likely reflects continued availability of the drug in communities, as well as expanded access to treatment through the Criminal Justice Treatment Account (CJTA). The majority of adults admitted to DASA-funded treatment for methamphetamine administer the drug via routes other than injection. A large majority of individuals dependent on methamphetamine are polydrug users.

Treatment for methamphetamine addiction has been demonstrated to be effective in reducing arrests, convictions, and health care costs.¹

¹ Nordlund, D., et al. *Treatment of Stimulant Addiction Including Addiction to Methamphetamine Results in Lower Health Care Costs and Reduced Arrests and Convictions: Washington State Supplemental Security Income Recipients*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Approximately 20% of Adult Admissions to DASA-Funded Chemical Dependency Treatment Services are for Individuals with Co-Occurring Mental Health and Chemical Dependency Disorders.



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

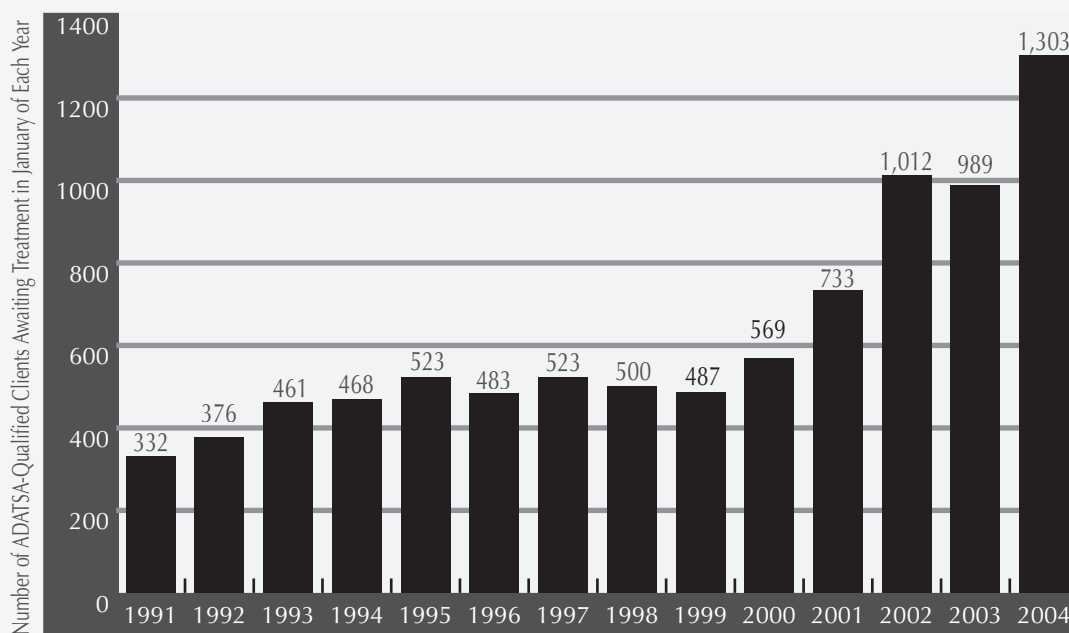
In SFY 2004, there were 6,149 admissions to DASA-funded treatment services of individuals who received a psychiatric evaluation, with results revealing a positive indication for a mental health problem. Some 2% of admissions were of individuals who had spent 15 or more days in the past year in a psychiatric hospital.

Integrated treatment for mental health and chemical dependency disorders has proven effective in enhancing health-related outcomes and reducing use of acute care services.¹

¹ Maynard, C., et al. "Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services & Research* 26(2), May 1999.



The Waiting List in Washington State for Treatment Under the Alcohol and Drug Abuse Treatment and Support Act Has Quadrupled Since 1991.

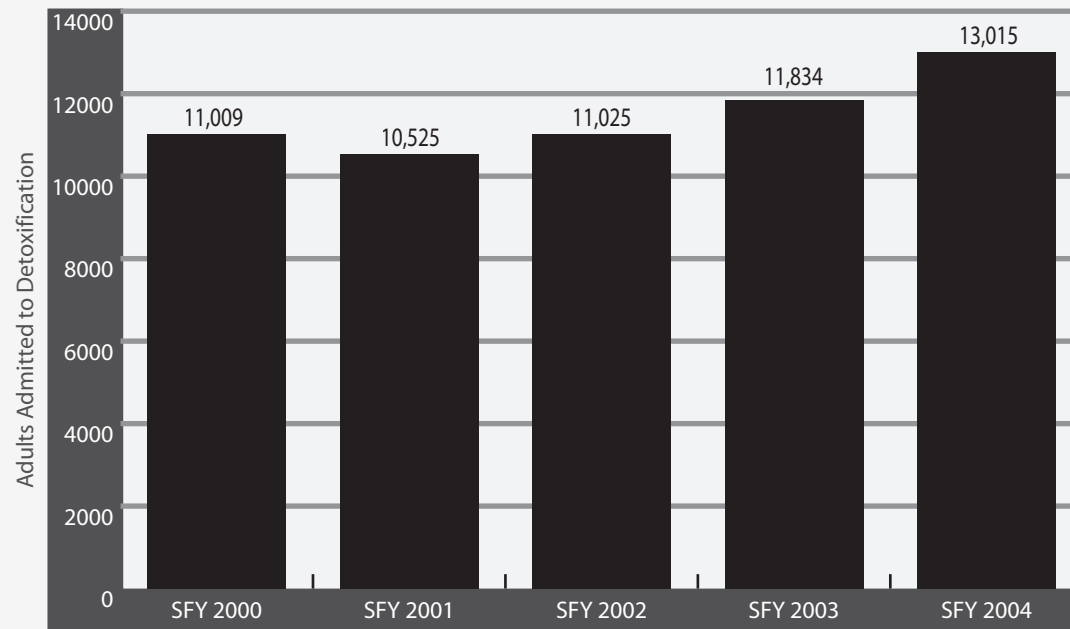


Source: Washington State Division of Alcohol and Substance Abuse, April 2004.

In 1989, the Washington State Legislature recognized in statute that, “alcoholism and drug addiction are treatable diseases, and that most persons with this illness can recover” (RCW 74.50.011). Under the Alcohol and Drug Abuse Treatment and Support Act (ADATSA), assessment, treatment, and support services are provided for individuals who are incapacitated from receipt of gainful employment and meet specific eligibility requirements.

The waiting list for ADATSA treatment services has quadrupled since 1991, and its growth is accelerating. Some of this growth is attributable to increased emphasis on treatment completion and retention, which has been shown to result in better outcomes. However, as of the second quarter of SFY, 2004, 47% of ADATSA clients already assessed as needing treatment are never admitted to treatment at all.

The Number of Adult Admissions to DASA-Funded Detoxification is Increasing.

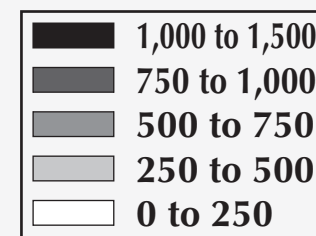
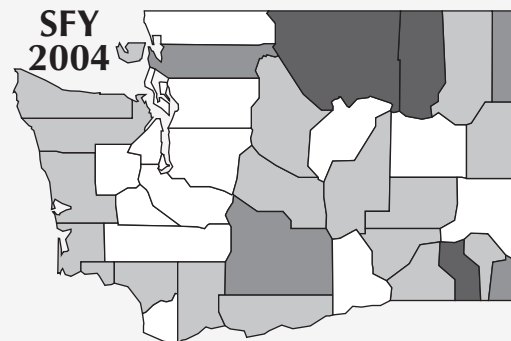
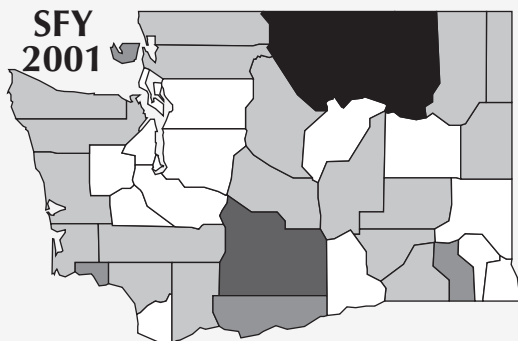
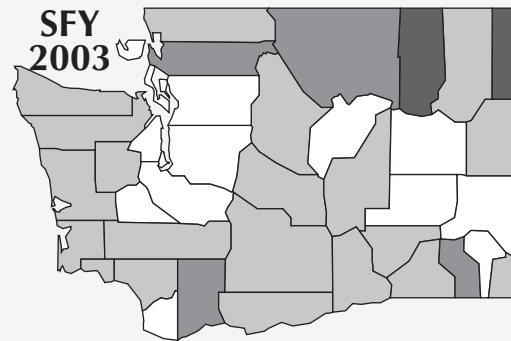
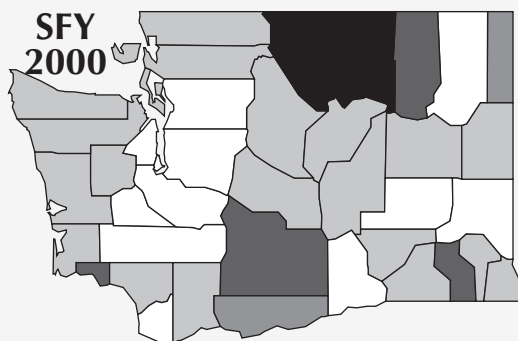
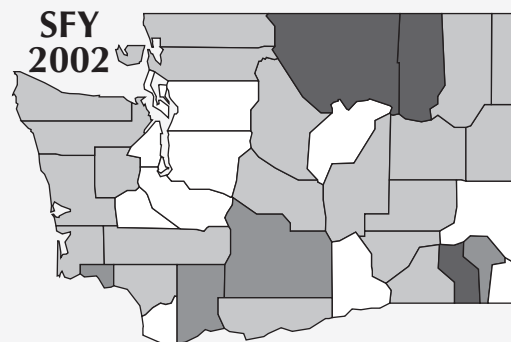
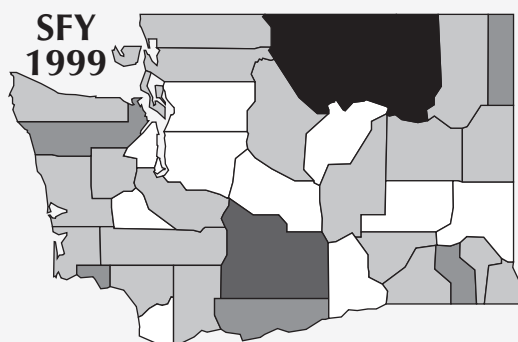


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that the number of adult admissions to DASA-funded detoxification services has risen steadily over the past three years. The number of DASA-funded detoxifications for methamphetamine has almost doubled, from 565 in SFY 2000, to 1,098 in SFY 2004.

Detoxification is part of the array of services available to people in crisis, and is often a necessary precursor to chemical dependency treatment.

Washington State Adult Treatment Admissions for Alcohol Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service

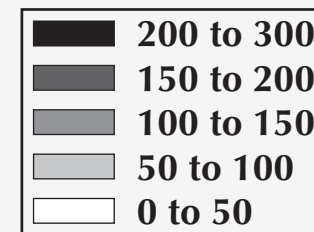
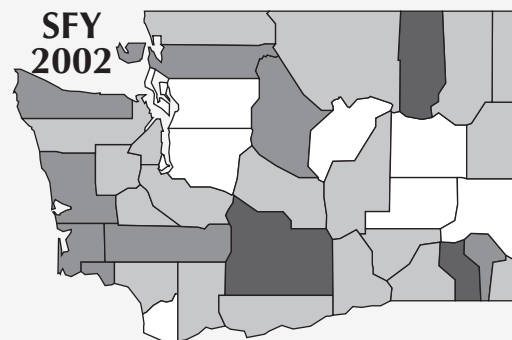
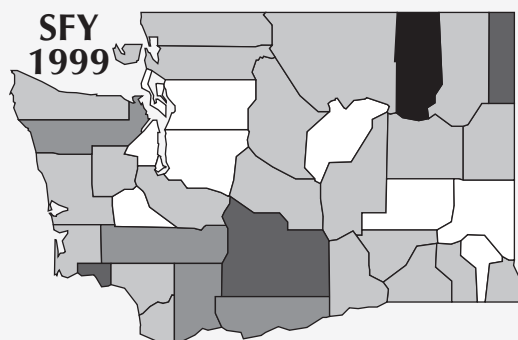


Washington State Adult Treatment Admissions* Primary Drug = Alcohol

County Name	SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003		SFY 2004	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	39	240.9	30	182.6	43	259.0	55	331.1	32	192.8	48	287.4
Asotin	64	310.5	63	306.6	49	236.7	23	111.1	55	267.0	118	570.0
Benton	322	229.3	300	210.6	309	213.4	354	239.8	404	266.5	367	236.6
Chelan	279	417.0	310	465.4	259	386.0	232	343.2	218	321.1	256	374.3
Clallam	261	405.5	268	415.3	319	492.3	236	363.6	270	413.5	280	424.9
Clark	600	177.7	629	182.2	718	203.6	649	178.6	551	148.0	583	152.1
Columbia	32	749.1	32	787.4	24	585.4	33	804.9	27	658.5	36	878.0
Cowlitz	366	394.8	425	457.2	440	468.6	384	406.8	358	377.2	341	357.8
Douglas	71	218.3	85	260.7	74	225.6	57	172.2	59	175.6	67	195.9
Ferry	100	1,375.3	69	950.4	79	1,082.2	60	821.9	81	1,109.6	58	794.5
Franklin	174	360.2	171	346.5	178	353.2	196	382.1	181	337.7	171	300.0
Garfield	9	376.9	7	292.0	1	41.7	12	500.0	2	83.3	7	291.7
Grant	186	252.9	205	274.4	209	275.4	235	307.6	237	307.4	277	353.8
Grays Harbor	274	406.8	237	352.7	217	316.8	214	312.9	221	321.2	243	351.2
Island	197	279.4	207	289.3	151	208.6	153	209.3	147	198.6	182	243.3
Jefferson	143	557.2	87	335.2	80	306.5	71	266.9	83	310.9	104	385.2
King	4,238	246.4	3,929	226.2	3,351	190.6	3,100	174.7	2,482	139.5	2,616	146.3
Kitsap	395	172.1	373	160.8	374	160.2	559	238.2	557	235.0	590	246.3
Kittitas	85	246.1	98	293.7	113	332.4	103	296.0	143	406.2	108	301.7
Klickitat	101	537.4	135	704.6	113	585.5	80	414.5	51	264.2	72	373.1
Lewis	183	267.0	149	217.2	168	241.7	210	299.1	184	261.4	169	239.0
Lincoln	29	285.9	46	451.7	29	284.3	26	254.9	22	217.8	32	313.7
Mason	149	307.1	182	368.4	122	246.0	141	283.1	180	358.6	137	269.7
Okanogan	496	1,258.0	452	1,142.5	457	1,151.1	314	788.9	289	729.8	328	828.3
Pacific	57	271.7	75	357.4	62	295.2	99	471.4	81	387.6	91	433.3
Pend Oreille	80	686.5	81	690.4	58	491.5	54	457.6	95	805.1	67	563.0
Pierce	1,940	280.5	1,495	213.3	1,457	204.2	1,290	177.9	1,185	161.5	1,327	178.4
San Juan	51	363.8	53	376.5	74	513.9	50	342.5	34	229.7	59	390.7
Skagit	470	460.5	460	446.7	484	464.9	356	338.7	567	531.4	798	733.5
Skamania	29	302.6	33	334.3	30	303.0	57	575.8	57	575.8	44	435.6
Snohomish	1,437	242.9	1,491	246.0	1,477	238.8	1,018	162.1	1,239	194.4	1,201	186.3
Spokane	1,138	273.1	1,214	290.5	1,317	311.8	1,116	262.2	1,290	301.0	1,236	286.1
Stevens	118	304.4	97	242.1	112	277.9	131	324.3	140	344.8	139	341.5
Thurston	353	171.7	410	197.7	392	186.5	457	215.3	421	196.0	506	231.6
Wahkiakum	23	593.5	36	941.4	25	657.9	23	605.3	27	710.5	18	473.7
Walla Walla	184	333.9	171	309.9	184	333.3	146	263.5	219	392.5	209	368.6
Whatcom	777	473.0	782	468.8	815	477.7	736	427.4	597	342.1	568	320.4
Whitman	68	165.1	79	193.9	71	176.2	55	135.5	82	200.0	61	146.3
Yakima	1,998	893.6	1,904	855.4	1,959	872.6	1,472	654.2	1,322	585.0	1,436	631.2
Total	17,516	300.4	16,870	286.2	16,394	274.4	14,557	240.9	14,190	232.7	14,950	20.6

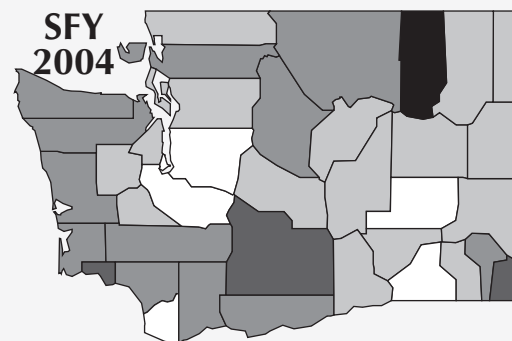
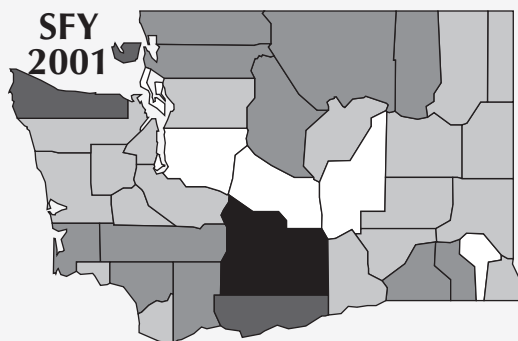
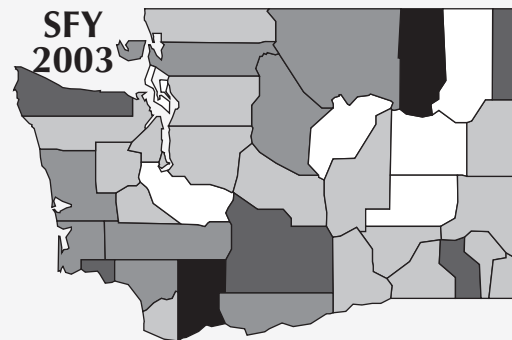
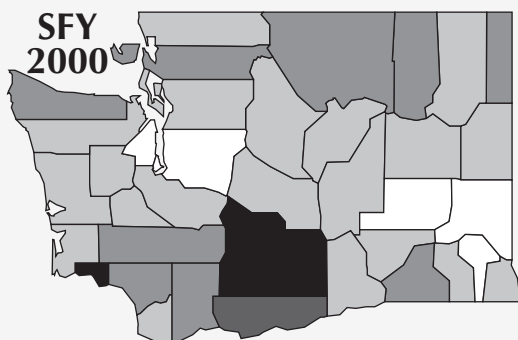
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Marijuana Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



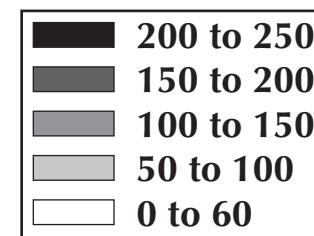
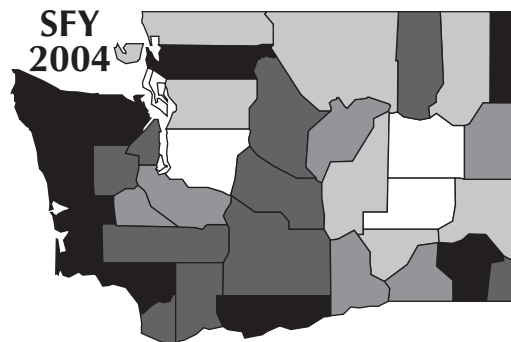
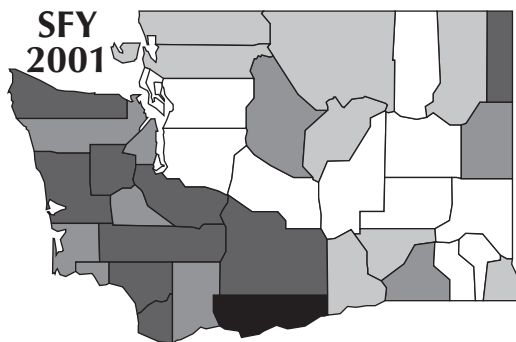
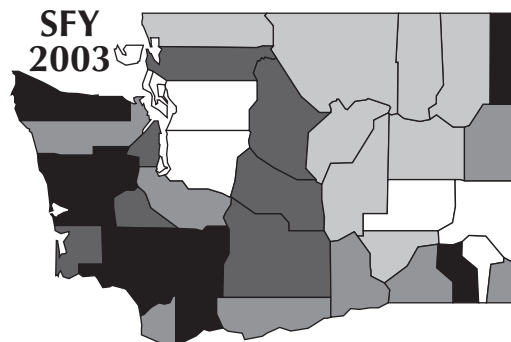
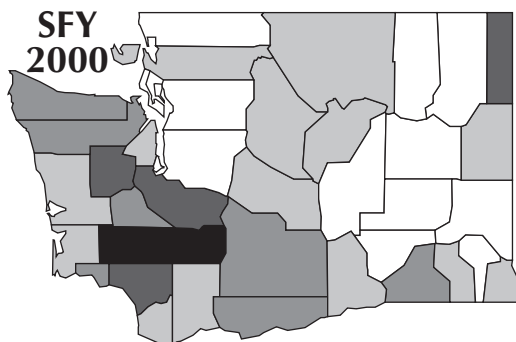
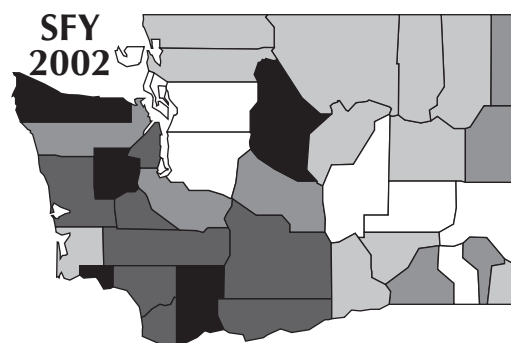
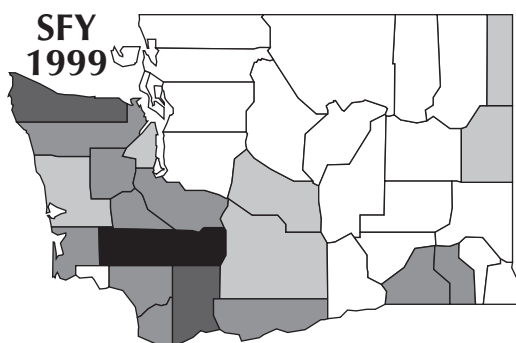


Washington State Adult Treatment Admissions* Primary Drug = Marijuana

County Name	SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003		SFY 2004	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	1	6.2	2	12.2	9	54.2	2	12.0	3	18.1	2	12.0
Asotin	12	58.2	13	63.3	14	67.6	18	87.0	15	72.8	34	164.3
Benton	93	66.2	86	60.4	121	83.6	111	75.2	114	75.2	99	63.8
Chelan	62	92.7	50	75.1	77	114.8	68	100.6	82	120.8	84	122.8
Clallam	73	113.4	91	141.0	125	192.9	80	123.3	107	163.9	91	138.1
Clark	210	62.2	194	56.2	307	87.1	214	58.9	195	52.4	177	46.2
Columbia	3	70.2	4	98.4	5	122.0	7	170.7	7	170.7	4	97.6
Cowlitz	67	72.3	106	114.0	100	106.5	81	85.8	113	119.1	129	135.4
Douglas	14	43.0	18	55.2	17	51.8	12	36.3	15	44.6	26	76.0
Ferry	16	220.1	9	124.0	9	123.3	11	150.7	16	219.2	16	219.2
Franklin	32	66.2	26	52.7	31	61.5	43	83.8	40	74.6	44	77.2
Garfield	0	0.0	0	0.0	1	41.7	3	125.0	2	83.3	3	125.0
Grant	38	51.7	42	56.2	28	36.9	56	73.3	52	67.4	69	88.1
Grays Harbor	56	83.1	47	69.9	51	74.5	77	112.6	87	126.5	83	119.9
Island	28	39.7	49	68.5	28	38.7	25	34.2	35	47.3	43	57.5
Jefferson	27	105.2	22	84.8	26	99.6	21	78.9	25	93.6	39	144.4
King	644	37.4	741	42.7	761	43.3	611	34.4	512	28.8	570	31.9
Kitsap	105	45.7	92	39.7	129	55.3	148	63.1	155	65.4	199	83.1
Kittitas	18	52.1	27	80.9	16	47.1	19	54.6	23	65.3	29	81.0
Klickitat	27	143.7	30	156.6	35	181.3	15	77.7	21	108.8	24	124.4
Lewis	74	108.0	76	110.8	72	103.6	55	78.3	82	116.5	75	106.1
Lincoln	6	59.1	6	58.9	7	68.6	3	29.4	5	49.5	8	78.4
Mason	26	53.6	46	93.1	45	90.7	25	50.2	50	99.6	42	82.7
Okanogan	25	63.4	45	113.7	51	128.5	38	95.5	52	131.3	52	131.3
Pacific	20	95.3	19	90.5	25	119.0	21	100.0	26	124.4	28	133.3
Pend Oreille	21	180.2	17	144.9	9	76.3	11	93.2	23	194.9	11	92.4
Pierce	546	79.0	578	82.5	591	82.8	426	58.8	442	60.2	514	69.1
San Juan	8	57.1	15	106.6	26	180.6	16	109.6	15	101.4	18	119.2
Skagit	100	98.0	119	115.6	128	123.0	116	110.4	129	120.9	146	134.2
Skamania	11	114.8	12	121.6	12	121.2	8	80.8	20	202.0	14	138.6
Snohomish	258	43.6	383	63.2	387	62.6	265	42.2	329	51.6	329	51.0
Spokane	308	73.9	373	89.2	397	94.0	264	62.0	250	58.3	277	64.1
Stevens	26	67.1	30	74.9	30	74.4	29	71.8	25	61.6	37	90.9
Thurston	92	44.8	135	65.1	138	65.7	174	82.0	189	88.0	167	76.4
Wahkiakum	7	180.6	8	209.2	3	78.9	4	105.3	7	184.2	6	157.9
Walla Walla	41	74.4	60	108.7	72	130.4	28	50.5	50	89.6	52	91.7
Whatcom	123	74.9	116	69.5	177	103.8	172	99.9	140	80.2	130	73.3
Whitman	9	21.8	14	34.4	25	62.0	14	34.5	22	53.7	22	52.8
Yakima	446	199.5	497	223.3	562	250.3	447	198.7	358	158.4	436	191.6
Total	3,673	63.0	4,198	71.2	4,647	77.8	3,738	61.9	3,833	62.9	4,129	66.9

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Methamphetamine Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service

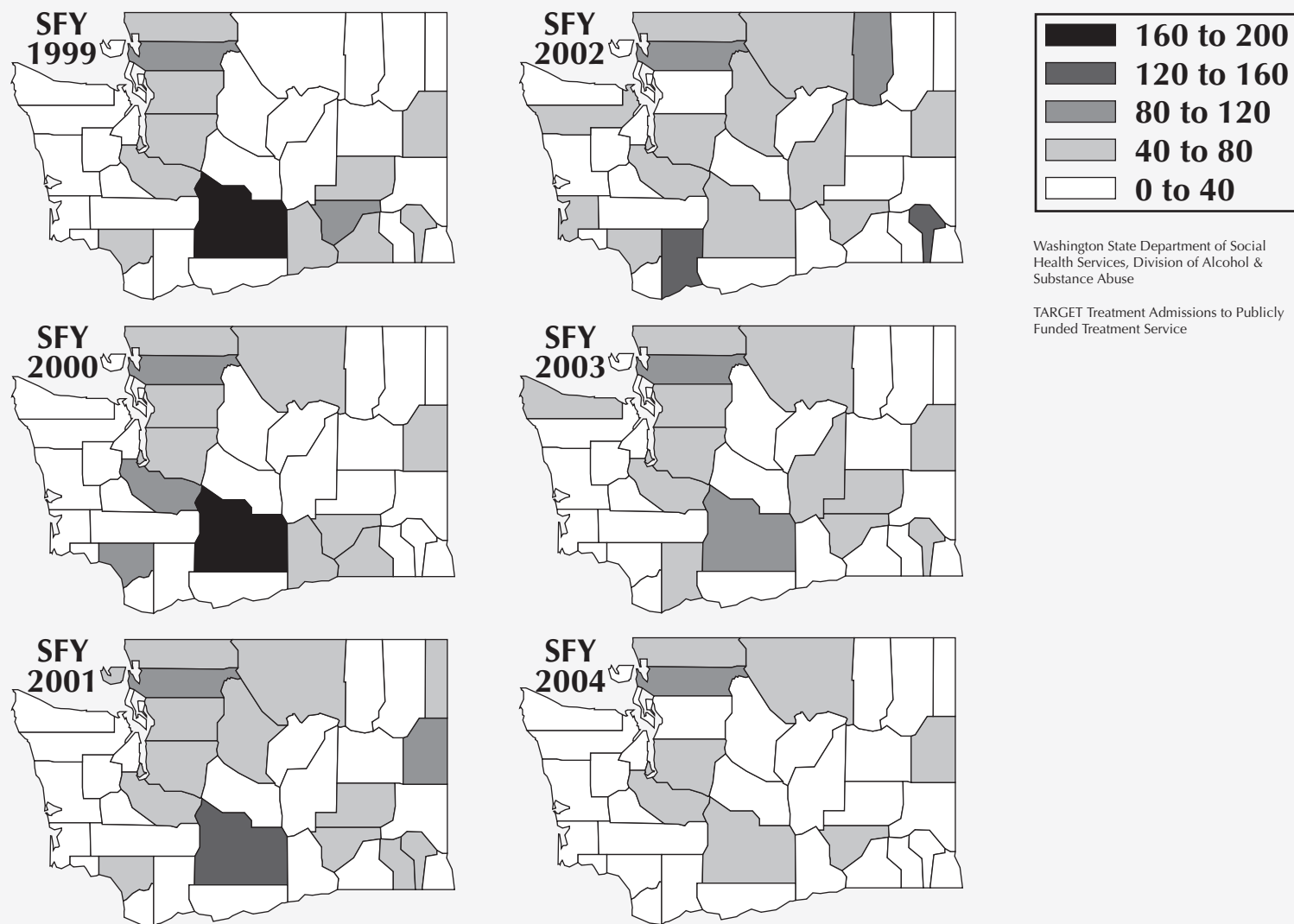


Washington State Adult Treatment Admissions* Primary Drug = Methamphetamine

County Name	SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003		SFY 2004	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	1	6.2	3	18.3	0	0.0	5	30.1	1	6.0	7	41.9
Asotin	10	48.5	16	77.9	20	96.6	21	101.4	25	121.4	37	178.7
Benton	69	49.1	87	61.1	131	90.5	165	111.8	156	102.9	177	114.1
Chelan	20	29.9	44	66.1	75	111.8	137	202.7	105	154.6	109	159.4
Clallam	100	155.4	91	141.0	105	162.0	152	234.2	204	312.4	225	341.4
Clark	478	141.6	493	142.8	679	192.6	576	158.5	542	145.6	581	151.6
Columbia	5	117.0	3	73.8	2	48.8	1	24.4	12	292.7	10	243.9
Cowlitz	130	140.2	169	181.8	181	192.8	185	196.0	261	275.0	276	289.6
Douglas	13	40.0	22	67.5	22	67.1	33	99.7	31	92.3	38	111.1
Ferry	0	0.0	0	0.0	3	41.1	5	68.5	7	95.9	11	150.7
Franklin	23	47.6	18	36.5	36	71.4	29	56.5	48	89.6	48	84.2
Garfield	1	41.9	0	0.0	0	0.0	4	166.7	1	41.7	5	208.3
Grant	11	15.0	12	16.1	22	29.0	36	47.1	67	86.9	69	88.1
Grays Harbor	56	83.1	59	87.8	105	153.3	126	184.2	149	216.6	148	2213.9
Island	13	18.4	20	27.9	34	47.0	32	43.8	29	39.2	37	49.5
Jefferson	38	148.1	32	123.3	32	122.6	28	105.3	28	104.9	60	222.2
King	397	23.1	454	26.1	580	33.0	659	37.1	488	27.4	679	38.0
Kitsap	178	77.5	206	88.8	271	116.1	363	154.7	406	171.3	422	176.2
Kittitas	21	60.8	30	89.9	14	41.2	43	123.6	53	150.6	56	156.4
Klickitat	24	127.7	21	109.6	48	248.7	34	176.2	21	108.8	48	248.7
Lewis	168	245.1	152	221.6	118	169.8	136	193.7	180	255.7	138	195.2
Lincoln	1	9.9	3	29.5	2	19.6	10	98.0	7	69.3	3	29.4
Mason	55	113.4	75	151.8	88	177.4	108	216.9	116	231.1	88	173.2
Okanogan	12	30.4	20	50.6	24	60.5	21	52.8	23	58.1	35	88.4
Pacific	22	104.9	11	52.4	26	123.8	33	157.1	34	162.7	47	223.8
Pend Oreille	8	68.6	22	187.5	19	161.0	13	110.2	34	288.1	30	252.1
Pierce	969	140.1	1108	158.1	1272	178.3	1079	148.8	889	121.2	870	116.9
San Juan	4	28.5	8	56.8	8	55.6	7	47.9	6	40.5	8	53.0
Skagit	41	40.2	72	69.9	99	95.1	103	98.0	190	178.1	240	220.6
Skamania	16	166.9	8	81.0	11	111.1	42	424.2	28	282.8	20	198.0
Snohomish	212	35.8	244	40.3	279	45.1	301	47.9	370	58.0	414	64.2
Spokane	294	70.6	372	89.0	522	123.6	462	108.6	557	130.0	637	147.5
Stevens	19	49.0	19	47.4	23	57.1	23	56.9	31	76.4	28	68.8
Thurston	209	101.7	222	107.1	265	126.1	342	161.1	327	152.2	306	140.0
Wahkiakum	1	25.8	5	130.8	5	131.6	10	263.2	12	315.8	8	210.5
Walla Walla	60	108.9	68	123.2	59	106.9	66	119.1	70	125.4	75	132.3
Whatcom	50	30.4	74	44.4	92	53.9	142	82.5	117	67.0	114	64.3
Whitman	7	17.0	6	14.7	10	24.8	19	46.8	10	24.4	23	55.2
Yakima	219	97.9	241	108.3	418	186.2	379	168.4	359	158.8	385	169.2
Total	3,955	67.8	4,510	76.5	5,700	95.4	5,930	98.2	5,994	98.3	6,512	105.6

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Cocaine Per 100,000 in Population



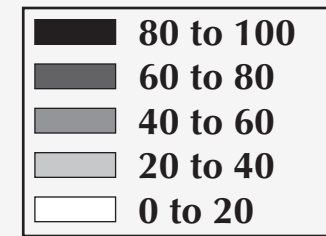
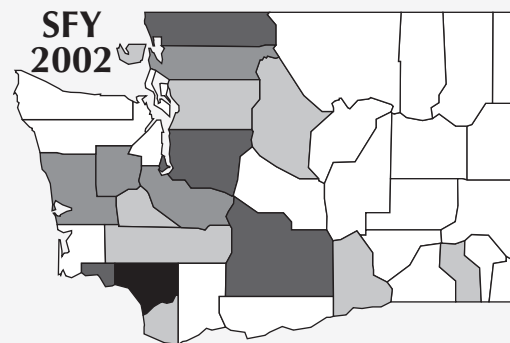
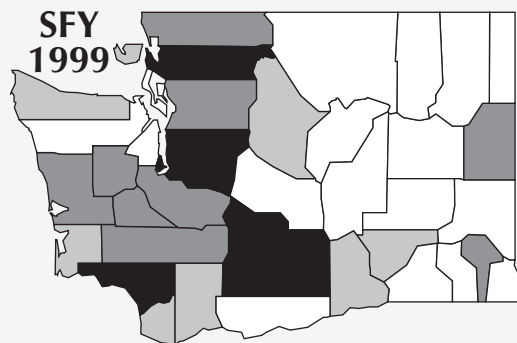


Washington State Adult Treatment Admissions* Primary Drug = Cocaine

County Name	SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003			
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	8	49.4	6	36.5	8	48.2	4	24.1	8	48.2	2	12.0
Asotin	3	14.6	2	9.7	1	4.8	0	0.0	0	0.0	0	0.0
Benton	77	54.8	57	40.0	53	36.6	46	31.2	37	24.4	41	26.4
Chelan	18	26.9	21	31.5	27	40.2	28	41.4	27	39.8	26	38.0
Clallam	20	31.1	14	21.7	16	24.7	14	21.6	32	49.0	20	30.3
Clark	117	34.7	84	24.3	109	30.9	116	31.9	88	23.6	113	29.5
Columbia	0	0.0	1	24.6	2	48.8	0	0.0	1	24.4	0	0.0
Cowlitz	46	49.6	83	89.3	71	75.6	51	54.0	33	34.8	35	36.7
Douglas	4	12.3	12	36.8	7	21.3	6	18.1	8	23.8	11	32.2
Ferry	1	13.8	1	13.8	0	0.0	6	82.2	1	13.7	2	27.4
Franklin	43	89.0	31	62.8	33	65.5	30	58.5	30	56.0	38	66.7
Garfield	1	41.9	0	0.0	1	41.7	3	125.0	1	41.7	0	0.0
Grant	21	28.6	28	37.5	20	26.4	40	52.4	38	49.3	33	42.1
Grays Harbor	25	37.1	16	23.8	20	29.2	7	10.2	16	23.3	19	27.5
Island	15	21.3	13	18.2	10	13.8	10	13.7	13	17.6	22	29.4
Jefferson	2	7.8	1	3.9	3	11.5	11	41.4	7	26.2	4	14.8
King	1372	79.8	1386	79.8	1223	69.6	974	54.9	895	50.3	960	53.7
Kitsap	47	20.5	53	22.8	53	22.7	61	26.0	69	29.1	98	40.9
Kittitas	2	5.8	7	21.0	4	11.8	5	14.4	9	25.6	3	8.4
Klickitat	2	10.6	4	20.9	3	15.5	1	5.2	1	5.2	2	10.4
Lewis	6	8.8	10	14.6	3	4.3	2	2.8	4	5.7	9	12.7
Lincoln	3	29.6	1	9.8	1	9.8	1	9.8	0	0.0	3	29.4
Mason	13	26.8	11	22.3	14	28.2	8	16.1	9	17.9	18	35.4
Okanogan	10	25.4	19	48.0	23	57.9	17	42.7	24	60.6	22	55.6
Pacific	5	23.8	5	23.8	4	19.0	12	57.1	6	28.7	5	23.8
Pend Oreille	1	8.6	2	17.0	6	50.8	2	16.9	3	25.4	0	0.0
Pierce	641	92.7	577	82.3	514	72.0	416	57.4	418	57.0	463	62.2
San Juan	0	0.0	3	21.3	9	62.5	5	34.2	3	20.3	3	19.9
Skagit	111	108.7	119	115.6	98	94.1	88	83.7	116	108.7	163	149.8
Skamania	1	10.4	1	10.1	2	20.2	15	151.5	5	50.5	4	39.6
Snohomish	377	63.7	355	58.6	351	56.7	243	38.7	273	42.8	273	42.3
Spokane	296	71.0	301	72.0	348	82.4	238	55.9	316	73.7	305	70.6
Stevens	6	15.5	9	22.5	4	9.9	8	19.8	12	29.6	3	7.4
Thurston	53	25.8	56	27.0	45	21.4	59	27.8	42	19.6	39	17.8
Wahkiakum	0	0.0	1	26.2	0	0.0	0	0.0	1	26.3	0	0.0
Walla Walla	25	45.4	23	41.7	16	29.0	8	14.4	12	21.5	21	37.0
Whatcom	81	49.3	99	59.3	105	61.5	87	50.5	119	68.2	90	50.8
Whitman	1	2.4	2	4.9	9	22.3	8	19.7	7	17.1	4	9.6
Yakima	400	178.9	365	164.0	359	159.9	280	124.4	229	101.3	221	97.1
Total	3,854	66.1	3,779	64.1	3,575	59.8	2,910	48.2	2,913	47.8	3,075	49.9

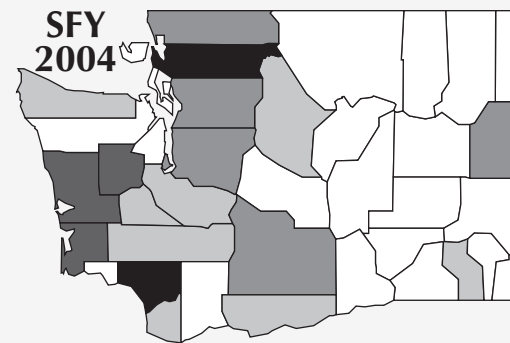
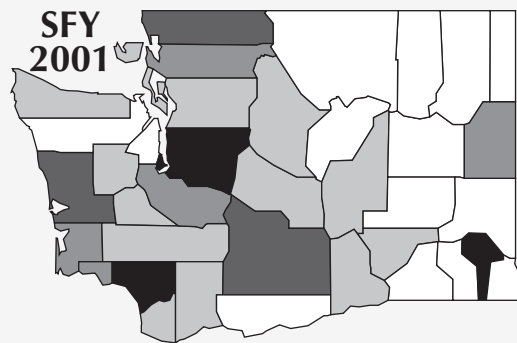
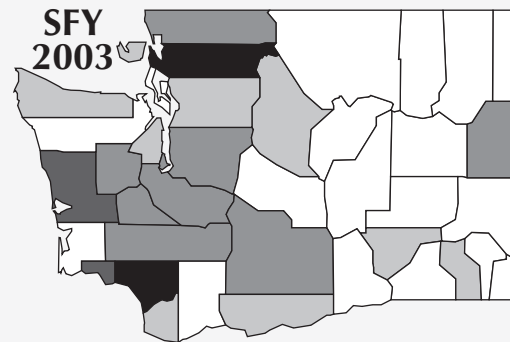
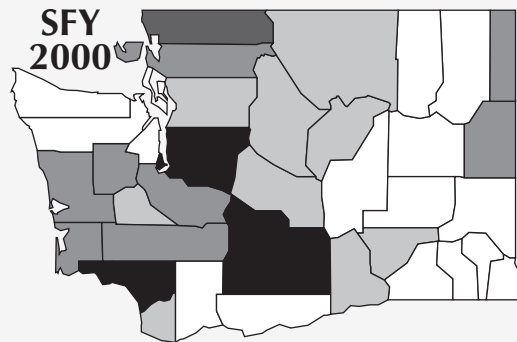
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Adult Treatment Admissions for Heroin Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service





Washington State Adult Treatment Admissions* Primary Drug = Heroin

County Name	SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003		SFY 2004	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	2	12.4	1	6.1	2	12.0	1	6.0	0	0.0	0	0.0
Asotin	2	9.7	3	14.6	4	19.3	0	0.0	1	4.9	1	4.8
Benton	55	39.2	33	23.2	34	23.5	31	21.0	22	14.5	18	11.6
Chelan	15	22.4	23	34.5	25	37.3	16	23.7	15	22.1	19	27.8
Clallam	20	31.1	12	18.6	14	21.6	8	12.3	16	24.5	22	33.4
Clark	118	35.0	113	32.7	125	35.5	131	36.0	112	30.1	96	25.0
Columbia	0	0.0	0	0.0	0	0.0	1	24.4	1	24.4	1	24.4
Cowlitz	86	92.8	158	170.0	93	99.0	89	94.3	91	95.9	90	94.4
Douglas	3	9.2	8	24.5	5	15.2	4	12.1	4	11.9	0	0.0
Ferry	0	0.0	1	13.8	0	0.0	0	0.0	0	0.0	1	13.7
Franklin	16	33.1	16	32.4	16	31.7	9	17.5	14	26.1	10	17.5
Garfield	1	41.9	0	0.0	2	83.3	0	0.0	0	0.0	0	0.0
Grant	10	13.6	8	10.7	22	29.0	5	6.5	12	15.6	3	3.8
Grays Harbor	33	49.0	39	58.0	45	65.7	31	45.3	55	79.9	45	65.0
Island	11	15.6	8	11.2	16	22.1	5	6.8	2	2.7	7	9.4
Jefferson	5	19.5	2	7.7	4	15.3	2	7.5	2	7.5	3	11.1
King	1382	80.3	1807	104.0	1406	80.0	1200	67.7	783	44.0	984	55.0
Kitsap	34	14.8	28	12.1	27	11.6	37	15.8	56	23.6	43	18.0
Kittitas	3	8.7	9	27.0	8	23.5	3	8.6	2	5.7	0	0.0
Klickitat	2	10.6	2	10.4	2	10.4	0	0.0	6	31.1	7	36.3
Lewis	38	55.4	30	43.7	17	24.5	20	28.5	36	51.1	28	39.6
Lincoln	1	9.9	1	9.8	0	0.0	1	9.8	1	9.9	2	19.6
Mason	25	51.5	27	54.7	19	38.3	22	44.2	32	63.7	32	63.0
Okanogan	1	2.5	8	20.2	3	7.6	2	5.0	3	7.6	6	15.2
Pacific	8	38.1	11	52.4	11	52.4	4	19.0	4	19.1	15	71.4
Pend Oreille	1	8.6	5	42.6	1	8.5	0	0.0	2	16.9	1	8.4
Pierce	396	57.3	342	48.8	414	58.0	367	50.6	321	43.8	264	35.5
San Juan	4	28.5	7	49.7	5	34.7	4	27.4	3	20.3	1	6.6
Skagit	92	90.1	60	58.3	55	52.8	46	43.8	93	87.2	152	139.7
Skamania	2	20.9	0	0.0	3	30.3	1	10.1	0	0.0	2	19.8
Snohomish	272	46.0	230	38.0	195	31.5	151	24.0	142	22.3	282	47.1
Spokane	201	48.2	246	58.9	223	52.8	174	40.9	203	47.4	178	41.2
Stevens	3	7.7	4	10.0	3	7.4	4	9.9	1	2.5	1	2.5
Thurston	108	52.5	71	34.2	78	37.1	83	39.1	120	55.9	78	35.7
Wahkiakum	5	129.0	6	156.9	2	52.6	3	78.9	3	78.9	0	0.0
Walla Walla	9	16.3	9	16.3	6	10.9	4	7.2	9	16.1	3	5.3
Whatcom	71	43.2	114	68.3	123	72.1	120	69.7	93	53.3	87	49.1
Whitman	2	4.9	0	0.0	0	0.0	0	0.0	8	19.5	1	2.4
Yakima	195	87.2	222	99.7	164	73.1	176	78.2	122	54.0	134	58.9
Total	3,232	55.4	3,664	62.2	3,172	53.1	2,755	45.6	2,390	39.2	2,617	42.4

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Treatment Admission Trends

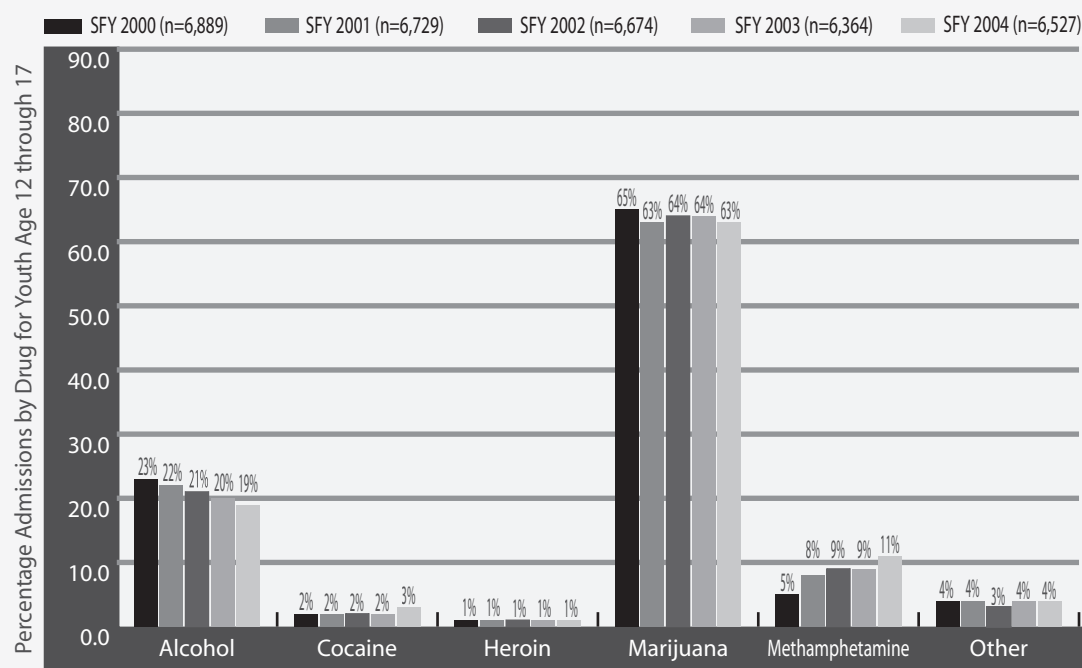
**Treatment
Admission**

Adult

Youth



Marijuana is the Most Frequently Cited Drug of Abuse in Youth Admissions to DASA-Funded Treatment.*



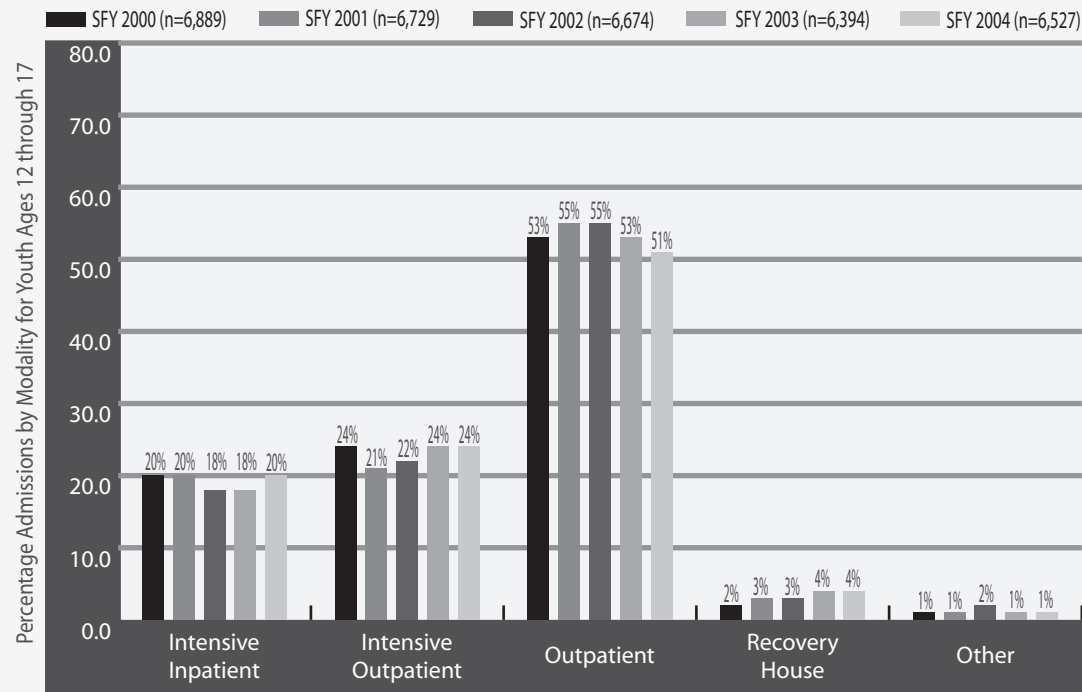
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that the majority of youth admissions to DASA-funded treatment are for marijuana. Youth admissions for methamphetamine abuse have almost doubled, from 371 in SFY 2000, to 732 in SFY 2004.

Note: Data may include multiple admissions for a single individual over the course of a year.

* Excludes detoxification and transitional housing.

The Majority of Youth Admissions to DASA-Funded Chemical Dependency Treatment are for Outpatient Services.*



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

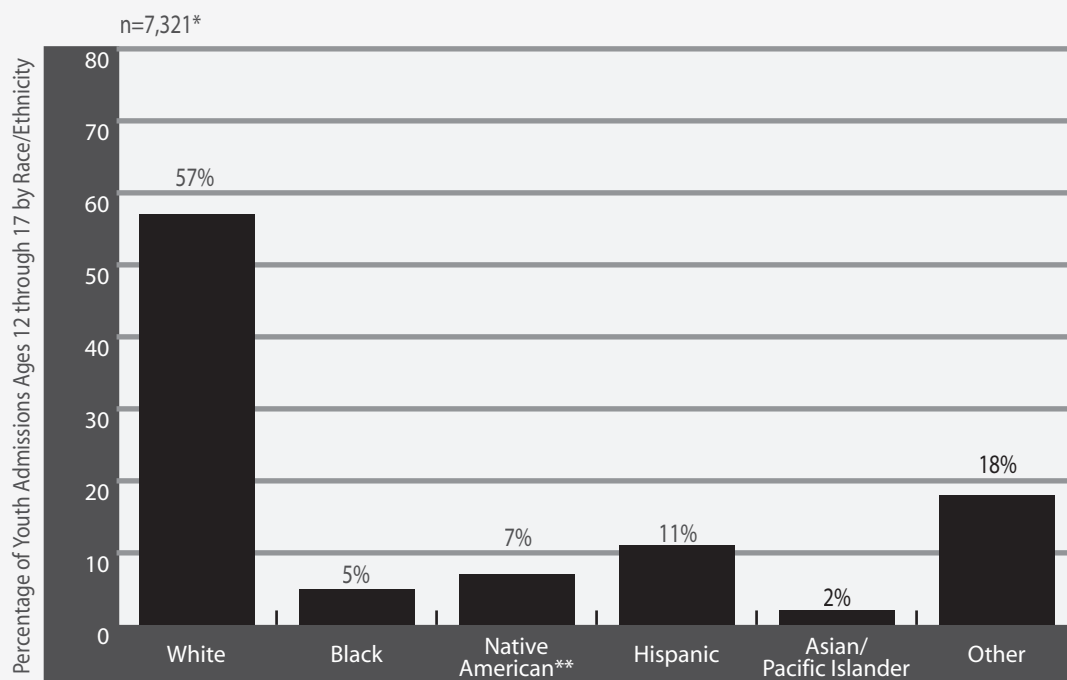
More than three quarters of youth admissions to DASA-funded chemical dependency treatment are for outpatient and intensive outpatient services.

Note: Data may include multiple admissions for a single individual over the course of a year. "Other" includes group care enhancement, recovery house, long-term residential, methadone, and treatment services for those with co-occurring disorders.

* Excludes detoxification and transitional housing.



Racial and Ethnic Minorities Comprise 43% of Youth Admissions to DASA-Funded Chemical Dependency Treatment Services.



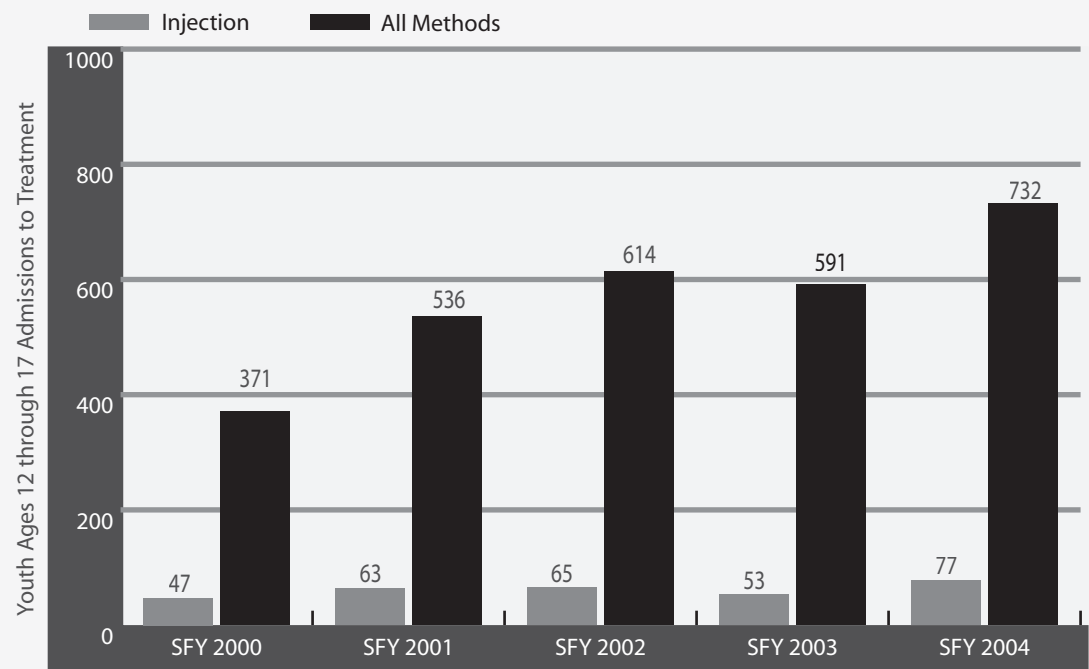
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that racial/ethnic minorities comprised approximately 43% of youth admissions to DASA-funded chemical dependency treatment in SFY 2004. Percentages of youth from different groups receiving DASA-funded treatment vary across modalities.

* In the U.S. Census, "Hispanic" is listed as an ethnicity, rather than as a racial group. Hence, Hispanic admissions may be duplicated in the racial categories.

** Includes Eskimo/Alaskan Native/Aleut

DASA-Funded Youth Treatment Admissions for Methamphetamine are Increasing.



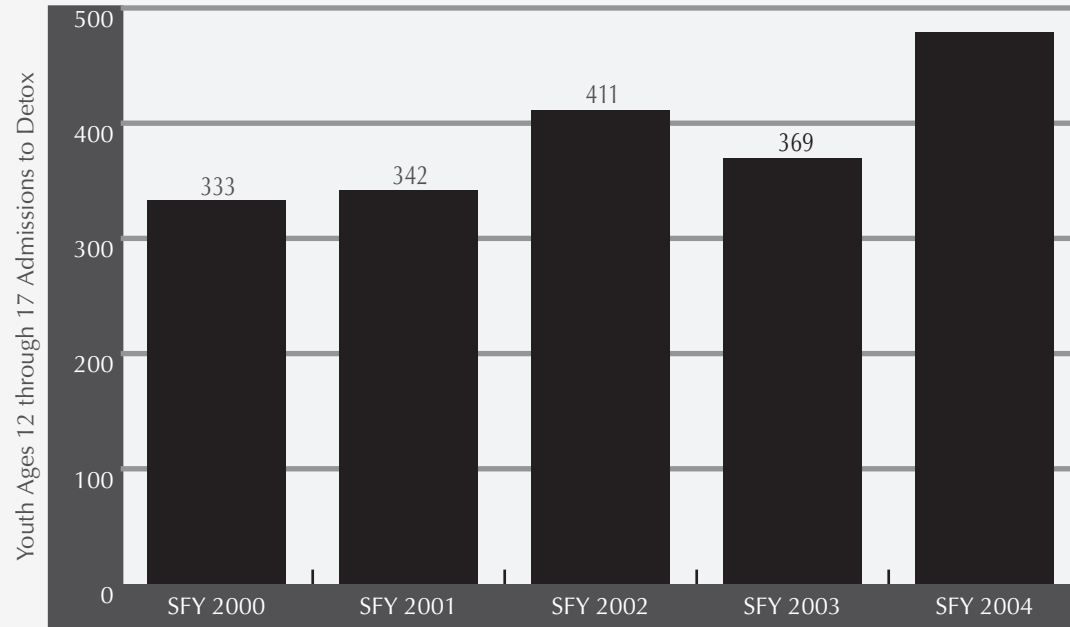
Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

DASA-funded youth treatment admissions for methamphetamine use continue to rise. Youth admissions in SFY 2004 (732) were almost double what they were in SFY 2000 (371). Youth are far less likely to inject methamphetamine than adults.

Note: Data exclude detoxification and transitional housing, private-pay, and Department of Corrections admission; includes total unduplicated admissions within counties.



The Number of Youth Admissions to DASA-Funded Detoxification is Rising.

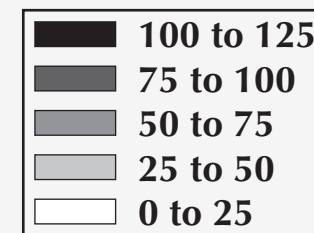
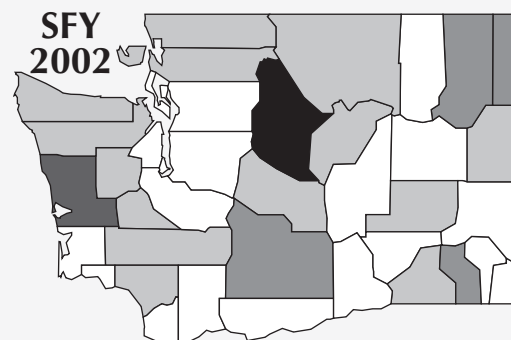
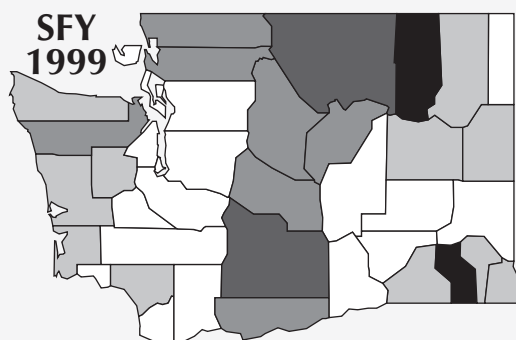


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Department of Social and Health Services.

This graph indicates that the number of youth admissions to DASA-funded detoxification services is rising. A plurality of DASA-funded youth admissions to detoxification services are for marijuana (209 in SFY 2004).

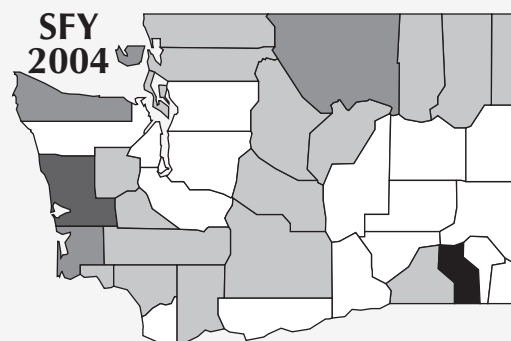
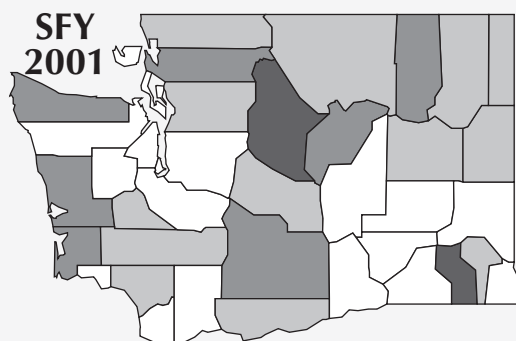
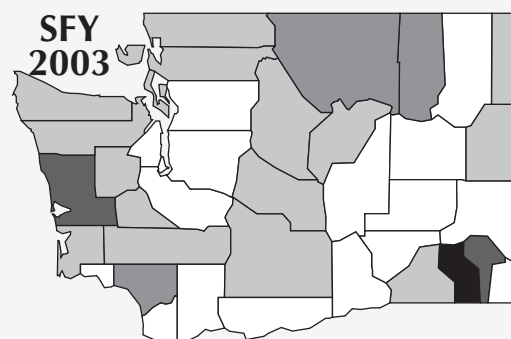
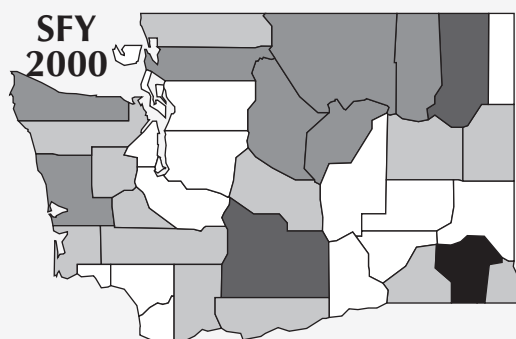
Detoxification is part of the array of services available to youth in crisis, and is often a necessary precursor to chemical dependency treatment.

Washington State Youth Treatment Admissions for Alcohol Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



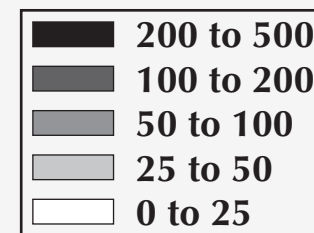
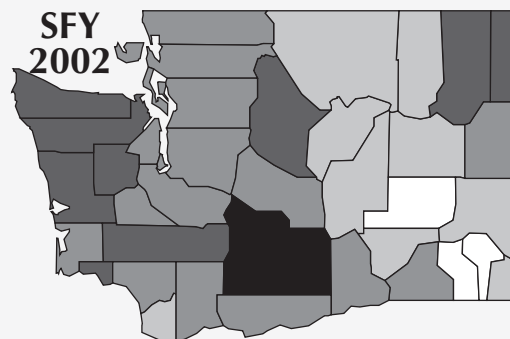
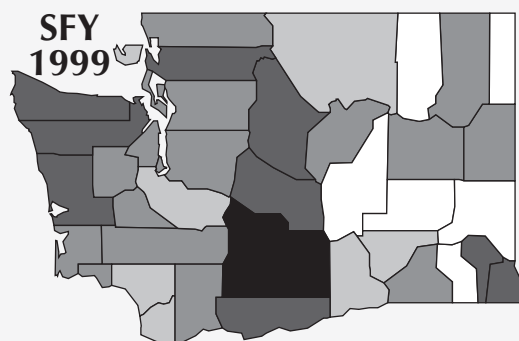


Washington State Youth Treatment Admissions * Primary Drug = Alcohol

County Name	SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003		SFY 2004	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	1	6.2	3	18.3	2	12.0	5	30.1	2	12.0	4	24.0
Asotin	10	48.5	6	29.2	2	9.7	0	0.0	4	19.0	2	10.0
Benton	16	11.4	27	19.0	14	9.7	18	12.2	32	21.0	25	16.0
Chelan	48	71.7	45	67.6	64	95.4	77	113.9	32	47.0	31	45.0
Clallam	32	49.7	45	69.7	34	52.5	24	37.0	20	31.0	40	61.0
Clark	6	13.6	40	11.6	35	9.9	39	10.7	37	10.0	26	7.0
Columbia	6	140.4	5	123.0	4	97.6	3	73.2	10	244.0	6	146.0
Cowlitz	24	25.9	23	24.7	26	27.7	29	30.7	47	50.0	27	28.0
Douglas	22	67.6	18	55.2	18	54.9	14	42.3	12	36.0	14	41.0
Ferry	9	123.8	4	55.1	5	68.5	0	0.0	5	68.0	3	41.0
Franklin	6	12.4	12	24.3	7	13.9	1	1.9	6	11.0	10	18.0
Garfield	1	41.9	5	208.6	1	41.7	0	0.0	2	83.0	0	0.0
Grant	11	15.0	8	10.7	5	6.6	11	14.4	10	13.0	11	14.0
Grays Harbor	33	49.0	45	67.0	48	70.1	52	76.0	54	78.0	53	77.0
Island	7	9.9	16	22.4	18	24.9	18	24.6	19	26.0	22	29.0
Jefferson	17	66.2	9	34.7	2	7.7	10	37.6	8	30.0	6	22.0
King	373	21.7	342	19.7	295	16.8	298	16.8	264	15.0	306	17.0
Kitsap	43	18.7	12	5.2	23	9.9	35	14.9	30	13.0	35	15.0
Kittitas	21	60.8	15	45.0	15	44.1	9	25.9	9	26.0	11	31.0
Klickitat	12	63.9	6	31.3	7	36.3	1	5.2	2	10.0	2	10.0
Lewis	17	24.8	32	46.6	25	36.0	32	45.6	30	43.0	21	30.0
Lincoln	4	39.4	5	49.1	5	49.0	1	9.8	0	0.0	1	10.0
Mason	11	22.7	15	30.4	3	6.0	14	28.1	21	42.0	18	35.0
Okanogan	39	98.9	28	70.8	14	35.3	18	45.2	18	45.0	27	68.0
Pacific	9	42.9	6	28.6	13	61.9	5	23.8	7	33.0	14	67.0
Pend Oreille	0	0.0	1	8.5	4	33.9	6	50.8	3	25.0	5	42.0
Pierce	129	18.7	125	17.8	102	14.3	84	11.6	87	12.0	101	14.0
San Juan	1	7.1	2	14.2	2	13.9	5	34.2	7	47.0	11	73.0
Skagit	76	74.5	74	71.9	52	50.0	37	35.2	33	31.0	29	27.0
Skamania	1	10.4	3	30.4	0	0.0	2	20.2	1	10.0	3	30.0
Snohomish	96	16.2	109	18.0	159	25.7	99	15.8	94	15.0	92	14.0
Spokane	127	30.5	119	28.5	137	32.4	128	30.1	116	27.0	93	22.0
Stevens	13	33.5	38	94.8	26	64.5	23	56.9	8	20.0	10	25.0
Thurston	51	24.8	52	25.1	81	38.5	74	34.9	82	38.0	56	26.0
Wahkiakum	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	26.0
Walla Walla	15	27.2	15	27.2	11	19.9	15	27.1	24	43.0	18	32.0
Whatcom	92	56.0	82	49.2	62	36.3	77	44.7	61	35.0	58	33.0
Whitman	7	17.0	2	4.9	3	7.4	2	4.9	3	7.0	6	14.0
Yakima	223	99.7	186	83.6	157	69.9	128	56.9	76	34.0	70	31.0
Total	1,649	28.3	1,580	26.8	1,481	24.8	1,394.0	23.1	1,276	20.9	1,268	20.6

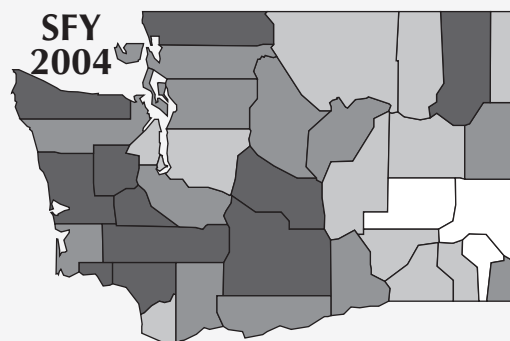
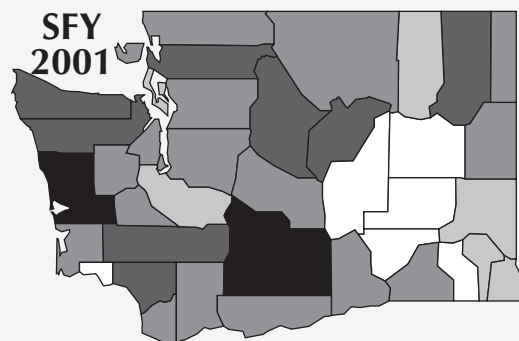
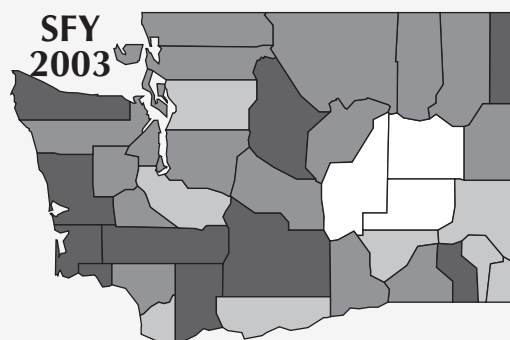
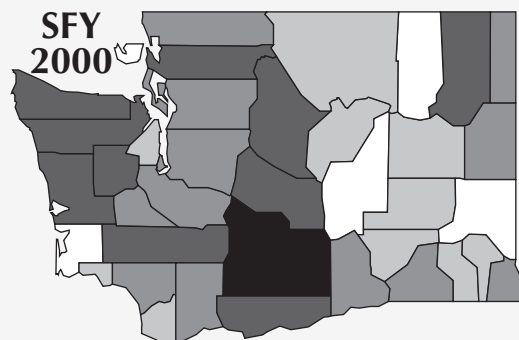
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Marijuana Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



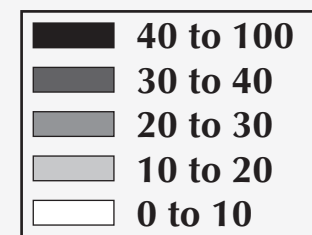
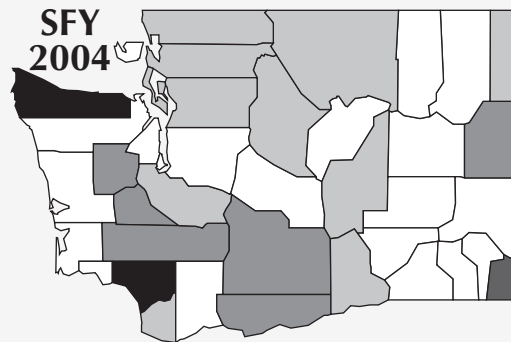
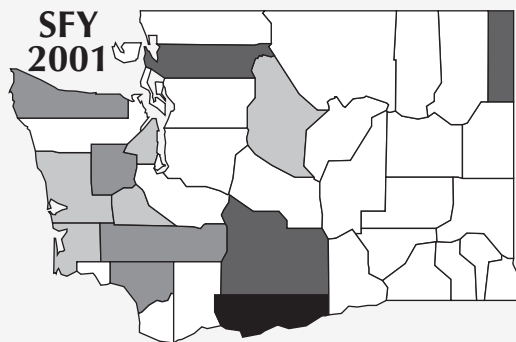
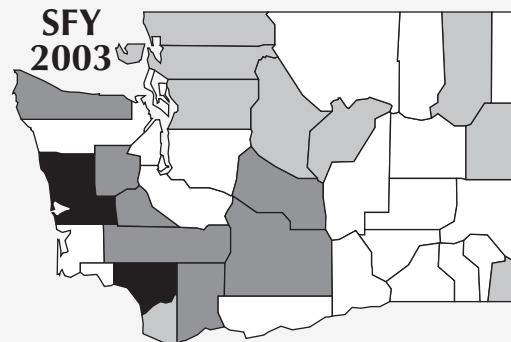
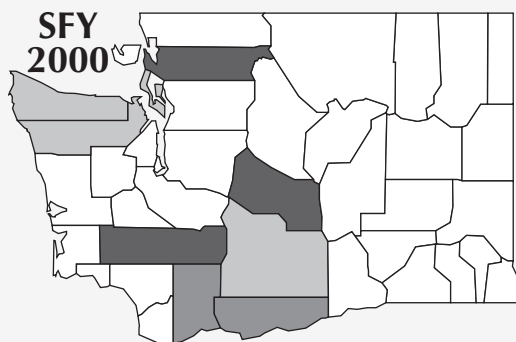
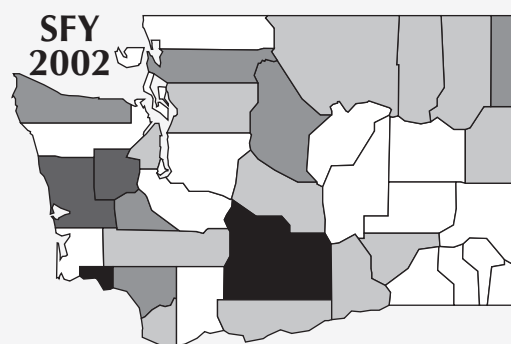
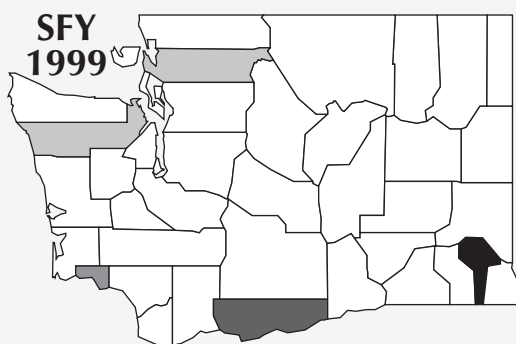


Washington State Youth Treatment Admissions * Primary Drug = Marijuana

County Name	SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003		SFY 2004	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	2	12.4	7	42.6	4	24.1	0	0.0	2	12.0	2	12.0
Asotin	21	101.9	18	87.6	6	29	10	48.3	6	29.1	12	58.0
Benton	50	35.6	79	55.4	83	57.3	96	65	91	60.0	79	50.9
Chelan	68	101.6	72	108.1	70	104.3	76	112.4	70	103.1	53	77.5
Clallam	81	125.8	112	173.6	85	131.2	75	115.6	85	130.2	112	170.0
Clark	162	48	157	45.5	193	54.7	139	38.2	166	44.6	165	43.0
Columbia	1	23.4	2	49.2	1	24.4	1	24.4	5	122.0	2	48.8
Cowlitz	38	41	80	86.1	85	90.5	65	68.9	91	95.9	125	131.2
Douglas	21	64.6	11	33.7	30	91.5	9	27.2	28	83.3	28	81.9
Ferry	1	13.8	1	13.8	3	41.1	2	27.4	6	82.2	2	27.4
Franklin	15	31.1	20	40.5	11	21.8	25	48.7	25	46.6	24	42.1
Garfield	3	125.6	1	41.7	1	41.7	0	0.0	1	41.7	0	0.0
Grant	14	19	15	20.1	18	23.7	28	36.6	19	24.6	26	33.2
Grays Harbor	129	191.5	97	144.4	144	210.2	108	157.9	104	151.2	96	138.7
Island	44	62.4	45	62.9	31	42.8	47	64.3	47	63.5	47	62.8
Jefferson	37	144.2	39	150.3	28	107.3	35	131.6	20	74.9	25	92.6
King	1012	58.8	1200	69.1	1016	57.8	978	55.1	922	51.8	877	49.0
Kitsap	120	52.3	83	35.8	118	50.6	153	65.2	89	37.6	89	37.2
Kittitas	36	104.2	42	125.9	19	55.9	30	86.2	24	68.2	42	117.3
Klickitat	22	117.1	25	130.5	16	82.9	12	62.2	5	25.9	11	57.0
Lewis	50	72.9	90	131.2	102	146.8	108	153.8	101	143.5	86	121.6
Lincoln	8	78.9	5	49.1	2	19.6	5	49	2	19.8	3	29.4
Mason	32	66	51	103.2	44	88.7	62	124.5	46	91.6	65	128.0
Okanogan	15	38	19	48	28	70.5	19	47.7	21	53.0	16	40.4
Pacific	16	76.3	4	19.1	19	90.5	17	81	40	191.4	14	66.7
Pend Oreille	0	0.0	7	59.7	7	59.3	17	144.1	12	101.7	1	8.4
Pierce	306	44.2	376	53.7	310	43.5	374	51.6	360	49.1	412	55.4
San Juan	6	42.8	3	21.3	9	62.5	12	82.2	12	81.1	8	53.0
Skagit	120	117.6	153	148.6	138	132.6	71	67.6	82	76.9	100	91.9
Skamania	6	62.6	7	70.9	6	60.6	9	90.9	12	121.2	9	89.1
Snohomish	300	50.7	388	64	349	56.4	338	53.8	310	48.6	339	52.6
Spokane	365	87.6	364	87.1	382	90.4	401	94.2	400	93.3	422	97.7
Stevens	35	90.3	45	112.3	60	148.9	47	116.3	31	76.4	41	100.7
Thurston	181	88.1	160	77.2	193	91.8	147	69.2	186	86.6	237	108.5
Wahkiakum	2	51.6	1	26.2	0	0.0	4	105.3	4	105.3	4	105.3
Walla Walla	32	58.1	35	63.4	42	76.1	35	63.2	47	84.2	28	49.4
Whatcom	132	80.3	155	92.9	137	80.3	168	97.6	152	87.1	190	107.2
Whitman	9	21.8	3	7.4	13	32.3	16	39.4	12	29.3	8	19.2
Yakima	568	254	526	236.3	480	213.8	473	210.2	417	184.5	352	154.7
Total	4,060	69.6	4,498	76.3	4,283	71.7	4,212	69.7	4,053	66.5	8,302	135.0

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Methamphetamine Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service

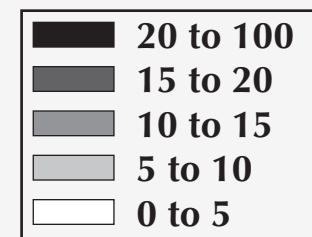
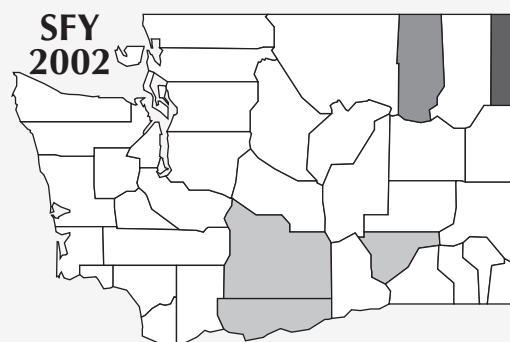
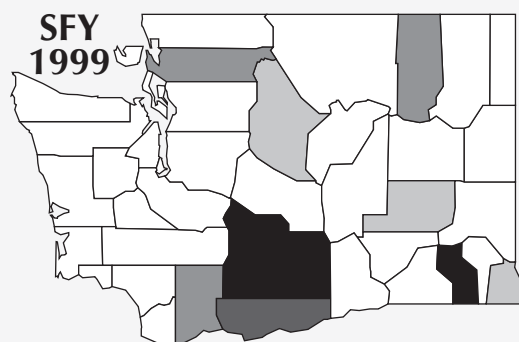


Washington State Youth Treatment Admissions* Primary Drug = Methamphetamine

County Name	SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003		SFY 2004	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Asotin	1	4.9	1	4.9	0	0.0	2	9.7	2	10.0	7	34.0
Benton	4	2.8	3	2.1	13	9.0	17	11.5	11	7.0	20	13.0
Chelan	4	6.0	4	6.0	15	22.4	14	20.7	11	16.0	9	13.0
Clallam	6	9.3	10	15.5	17	26.2	15	23.1	21	32.0	29	44.0
Clark	24	7.1	33	9.6	31	8.8	48	13.2	37	10.0	46	12.0
Columbia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Cowlitz	5	5.4	9	9.7	26	27.7	27	28.6	53	56.0	45	47.0
Douglas	1	3.1	0	0.0	3	9.1	2	6.0	4	12.0	3	9.9
Ferry	10	0.0	0	0.0	0	0.0	1	13.7	0	0.0	1	14.0
Franklin	0	0.0	2	4.1	3	6.0	6	11.7	2	4.0	1	2.0
Garfield	1	41.9	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grant	0	0.0	0	0.0	1	1.3	5	6.5	0	0.0	11	14.0
Grays Harbor	5	7.4	6	8.9	12	17.5	23	33.6	29	42.0	21	30.0
Island	8	11.3	11	15.4	3	4.1	4	5.5	3	4.0	10	13.0
Jefferson	3	11.7	5	19.3	2	7.7	4	15.0	2	7.0	2	7.0
King	39	2.3	68	3.9	70	4.0	75	4.2	82	5.0	78	4.0
Kitsap	8	3.5	26	11.2	31	13.3	31	13.2	15	6.0	21	9.0
Kittitas	4	11.6	11	33.0	5	14.7	5	14.4	7	20.0	3	8.0
Klickitat	0	0.0	5	26.1	11	57.0	2	10.4	0	0.0	4	21.0
Lewis	8	11.7	26	37.9	21	30.2	14	19.9	18	26.0	19	27.0
Lincoln	0	0.0	1	9.8	0	0.0	0	0.0	1	10.0	0	0.0
Mason	2	4.1	7	14.2	14	28.2	15	30.1	11	22.0	12	24.0
Okanogan	1	2.5	0	0.0	2	5.0	4	10.1	2	5.0	6	15.0
Pacific	1	4.8	3	14.3.0	3	14.3	2	9.5	1	5.0	1	5.0
Pend Oreille	0	0.0	1	8.5	4	33.9	3	25.4	0	0.0	1	8.0
Pierce	40	5.8	54	7.7	64	9.0	40	5.5	65	9.0	72	10.0
San Juan	0	0.0	0	0.0	3	20.8	0	0.0	2	14.0	1	7.0
Skagit	19	18.6	34	33.0	42	40.3	23	21.9	13	12.0	19	17.0
Skamania	1	10.4	1	10.1	0	0.0	0	0.0	3	30.0	3	30.0
Snohomish	20	3.4	27	4.5	38	6.1	65	10.4	61	10.0	85	13.0
Spokane	15	3.6	40	9.6	42	9.9	51	12.0	57	13.0	94	22.0
Stevens	0	0.0	1	2.5	3	7.4	6	14.9	4	10.0	2	5.0
Thurston	17	8.3	11	5.3	40	19.0	45	21.2	42	20.0	59	27.0
Wahkiakum	1	25.8	0	0.0	0	0.0	2	52.6	0	0.0	0	0.0
Walla Walla	3	5.4	2	3.6	3	5.4	3	5.4	5	9.0	3	5.0
Whatcom	8	4.9	17	10.2	14	8.2	17	9.9	22	13.0	29	16.0
Whitman	1	2.4	1	2.5	1	2.5	0	0.0	0	0.0	3	7.0
Yakima	20	8.9	34	15.3	80	35.6	102	45.3	45	20.0	50	22.0
Total	270	4.6	454	7.7	617	10.3	673	11.1	631	10.3	1,540	25.0

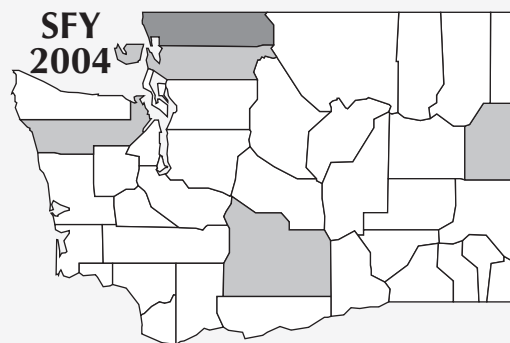
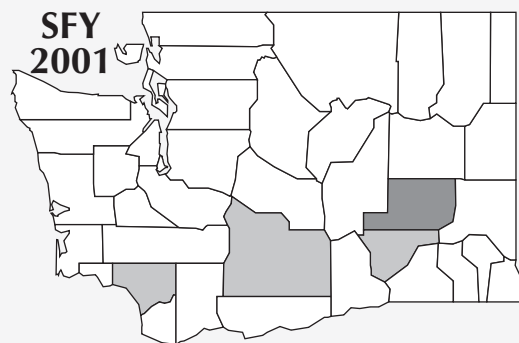
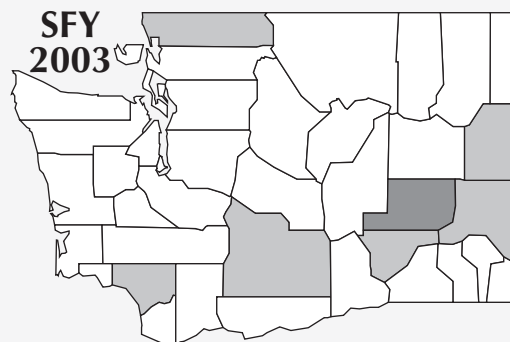
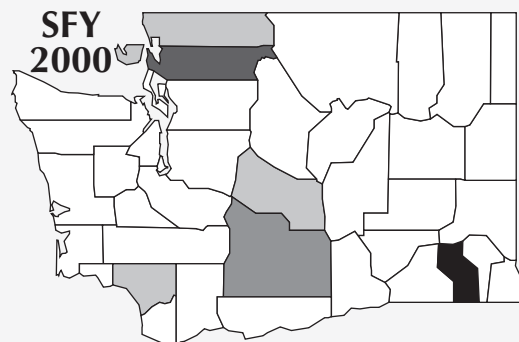
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Cocaine Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



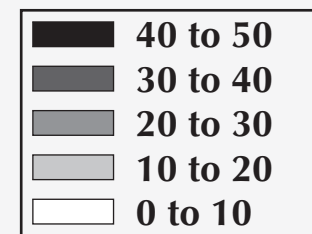
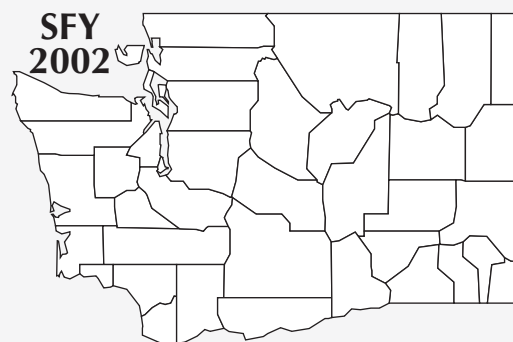
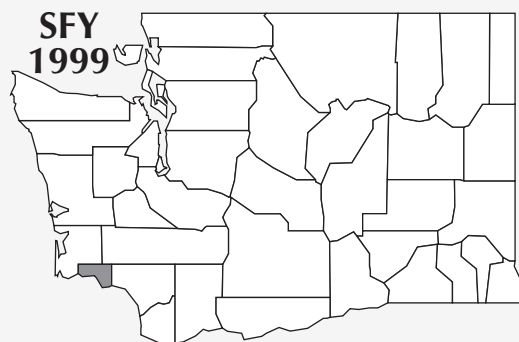


Washington State Youth Treatment Admissions* Primary Drug = Cocaine

County Name	SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003		SFY 2004	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	1	6.2	0	0.0	2	12.0	0	0.0	2	12.0	0	0.0
Asotin	2	9.7	0	0.0	0	0.0	1	4.8	0	0.0	0	0.0
Benton	1	0.7	2	1.4	4	2.8	1	0.7	3	2.0	1	0.6
Chelan	4	6.0	0	0.0	3	4.5	2	3.0	2	2.9	0	0.0
Clallam	0	0.0	0	0.0	0	0.0	0	0.0	1	1.5	1	1.5
Clark	2	0.6	3	0.9	2	0.6	3	0.8	1	0.3	2	0.5
Columbia	1	23.4	1	24.6	0	0.0	0	0.0	0	0.0	0	0.0
Cowlitz	1	1.1	7	7.5	7	7.5	3	3.2	7	7.4	4	4.2
Douglas	0	0.0	0	0.0	1	3.0	0	0.0	0	0.0	1	2.9
Ferry	1	13.8	0	0.0	0	0.0	1	13.7	0	0.0	0	0.0
Franklin	1	2.1	0	0.0	4	7.9	5	9.7	3	5.6	1	1.8
Garfield	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grant	2	2.7	2	2.7	1	1.3	2	2.6	1	1.3	1	1.3
Grays Harbor	1	1.5	0	0.0	2	2.9	2	2.9	1	1.5	3	4.3
Island	3	4.3	0	0.0	0	0.0	2	2.7	2	2.7	3	4.0
Jefferson	0	0.0	0	0.0	1	3.8	0	0.0	1	3.7	2	7.4
King	46	2.7	35	2.0	33	1.9	13	0.7	21	1.2	35	2.0
Kitsap	4	1.7	2	0.9	0	0.0	1	0.4	0	0.0	3	1.3
Kittitas	1	2.9	3	9.0	0	0.0	0	0.0	1	2.8	0	0.0
Klickitat	3	16.0	0	0.0	0	0.0	1	5.2	0	0.0	0	0.0
Lewis	0	0.0	2	2.9	1	1.4	0	0.0	0	0.0	1	1.4
Lincoln	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Mason	2	4.1	2	4.0	1	2.0	0	0.0	1	2.0	1	2.0
Okanogan	1	2.5	1	2.5	1	2.5	0	0.0	2	5.1	1	2.5
Pacific	1	4.8	1	4.8	0	0.0	0	0.0	0	0.0	0	0.0
Pend Oreille	0	0.0	0	0.0	0	0.0	2	16.9	0	0.0	0	0.0
Pierce	9	1.3	12	1.7	2	0.3	4	0.6	10	1.4	11	1.5
San Juan	0	0.0	1	7.1	0	0.0	0	0.0	0	0.0	1	6.6
Skagit	13	12.7	16	15.5	4	3.8	4	3.8	4	3.7	10	9.2
Skamania	1	10.4	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Snohomish	20	3.4	20	3.3	5	0.8	22	3.5	11	1.7	25	3.9
Spokane	12	2.9	11	2.6	11	2.6	17	4.0	29	6.8	28	6.5
Stevens	0	0.0	1	2.5	0	0.0	1	2.5	0	0.0	1	2.5
Thurston	3	1.5	6	2.9	1	0.5	5	2.4	2	0.9	0	0.0
Wahkiakum	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Walla Walla	0	0.0	1	1.8	0	0.0	1	1.8	0	0.0	2	3.5
Whatcom	5	3.0	11	6.6	7	4.1	8	4.6	10	5.7	19	10.7
Whitman	0	0.0	0	0.0	0	0.0	1	2.5	3	7.3	0	0.0
Yakima	58	25.9	30	13.5	21	9.4	21	9.3	19	8.4	18	7.9
Total	199	3.4	170	2.9	114	1.9	123	2	137	2.2	175	2.8

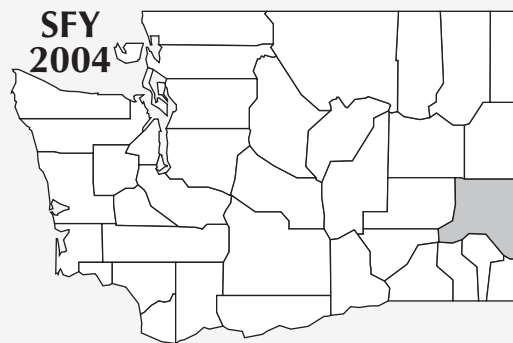
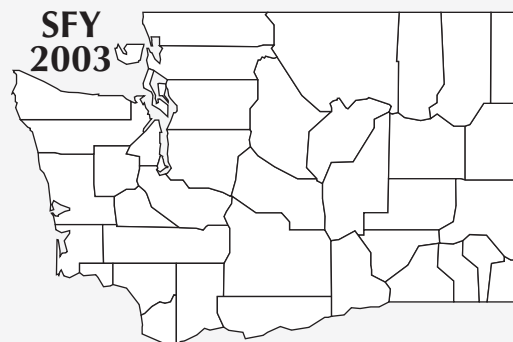
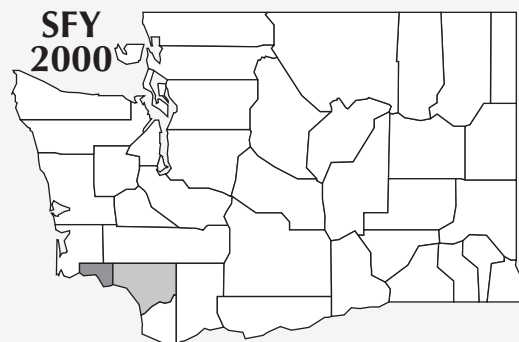
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Washington State Youth Treatment Admissions for Heroin Per 100,000 in Population



Washington State Department of Social Health Services, Division of Alcohol & Substance Abuse

TARGET Treatment Admissions to Publicly Funded Treatment Service



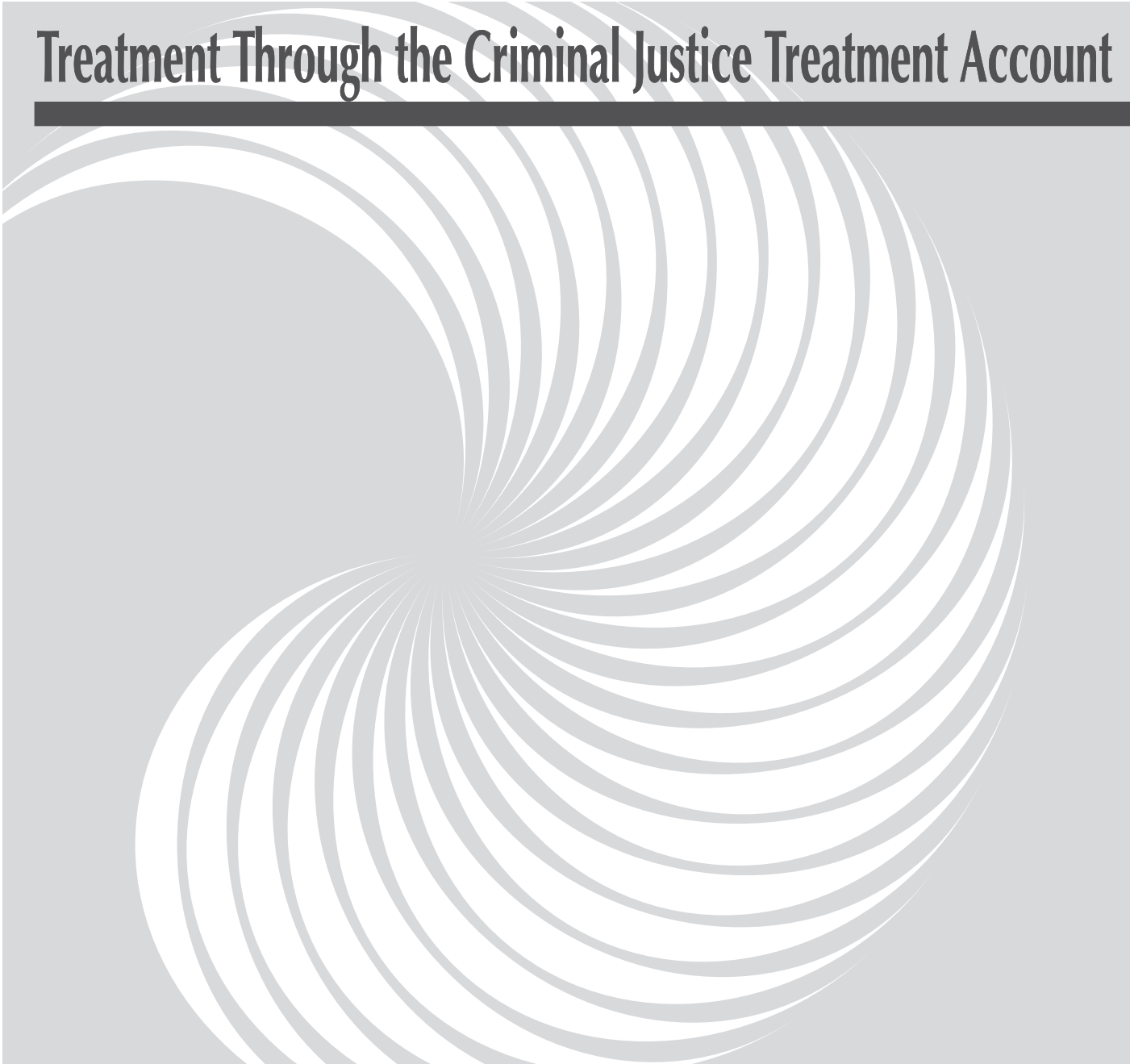


Washington State Youth Treatment Admissions* Primary Drug = Heroin

County Name	SFY 1999		SFY 2000		SFY 2001		SFY 2002		SFY 2003		SFY 2004	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Adams	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Asotin	0	0.0	0	0.0	0	0.0	1	4.8	0	0.0	0	0.0
Benton	1	0.7	0	0.0	1	0.7	2	1.4	1	0.7	1	0.6
Chelan	1	1.5	0	0.0	1	1.5	1	1.5	0	0.0	0	0.0
Clallam	1	1.6	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Clark	4	1.2	0	0.0	1	0.3	0	0.0	2	0.5	5	1.3
Columbia	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Cowlitz	3	3.2	12	12.9	10	10.6	3	3.2	4	4.2	3	3.1
Douglas	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Ferry	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Franklin	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Garfield	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grant	0	0.0	0	0.0	1	1.3	0	0.0	0	0.0	0	0.0
Grays Harbor	1	1.5	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Island	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Jefferson	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
King	21	1.2	14	0.8	15	0.9	6	0.3	8	0.4	5	0.3
Kitsap	1	0.4	3	1.3	0	0.0	4	1.7	0	0.0	3	1.3
Kittitas	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Klickitat	0	0.0	1	5.2	0	0.0	0	0.0	0	0.0	1	5.2
Lewis	0	0.0	3	4.4	1	1.4	1	1.4	1	1.4	0	0.0
Lincoln	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Mason	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Okanogan	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pacific	0	0.0	0	0.0	0	0.0	0	0.0	1	4.8	0	0.0
Pend Oreille	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pierce	0	0.0	2	0.3	1	0.1	4	0.6	3	0.4	3	0.4
San Juan	0	0.0	0	0.0	0	0.0	0	0.0	1	6.8	0	0.0
Skagit	8	7.8	4	3.9	1	1.0	2	1.9	1	0.9	0	0.0
Skamania	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Snohomish	3	0.5	4	0.7	4	0.6	0	0.0	3	0.5	4	0.6
Spokane	3	0.7	0	0.0	1	0.2	4	0.9	2	0.5	4	0.9
Stevens	0	0.0	0	0.0	0	0.0	1	2.5	3	7.4	0	0.0
Thurston	7	3.4	6	2.9	2	1.0	2	0.9	2	0.9	2	0.9
Wahkiakum	1	25.8	1	26.2	0	0.0	0	0.0	0	0.0	0	0.0
Walla Walla	0	0.0	1	1.8	0	0.0	0	0.0	0	0.0	0	0.0
Whatcom	3	1.8	4	2.4	5	2.9	3	1.7	3	1.7	7	3.9
Whitman	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	6	14.4
Yakima	6	2.7	15	6.7	15	6.7	7	3.1	1	0.4	4	1.8
Total	64	1.1	70	1.2	59	1	41	0.7	36	0.6	48	0.8

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

Treatment Through the Criminal Justice Treatment Account





Criminal Justice Treatment Account (CJTA)

In 2003, the Legislature and Governor created the Criminal Justice Treatment Account (CJTA). Its history goes back to the previous year, when in the 2002 Session, the Legislature effected a shift in adult felony drug offender sentencing policy, reducing sentences for many adult felony drug offenses, and designating the projected savings for use in providing substance abuse treatment for offenders, both in prison and in the community.

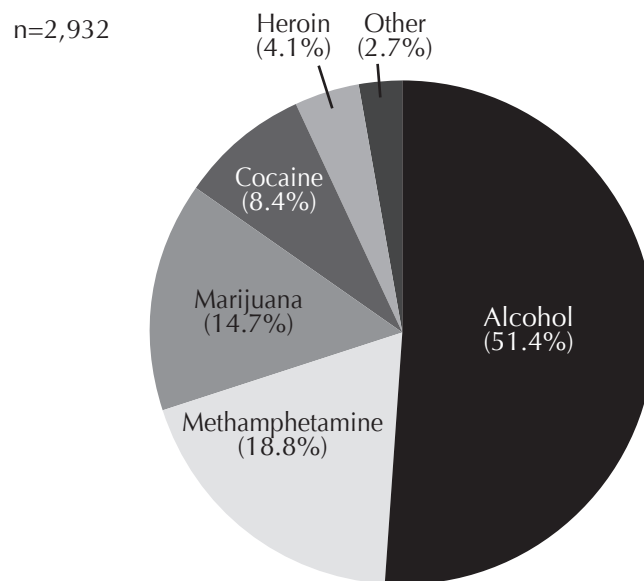
Beginning with the 2003-2005 Biennium, funds are transferred from the State General Fund into the Violence Reduction and Drug Enforcement (VRDE) account. Almost \$3 million was allocated to be used solely for providing substance abuse treatment to offenders confined in state prisons.

For the 2003-2005 Biennium, \$8,950,000 was transferred from the General Fund into the newly established Criminal Justice Treatment Account (CJTA). Administered by the Division of Alcohol and Substance Abuse (DASA), the CJTA funds are used solely for providing substance abuse treatment and treatment support services for offenders who have a substance abuse problem and have been filed upon by a county prosecutor. The intent is to provide judicially supervised treatment in lieu of incarceration, with the objective of generating additional jail and prison bed savings, both in the short-term through treating offenders rather than incarcerating them, and in the long-term by reducing recidivism among those offenders. Use of the funds is determined at the county level, and may include drug courts, provided the funds are used only for treatment and treatment support services.

For SFY 2006, and every fiscal year thereafter, \$8,250,000 is to be transferred into the CJTA for the purposes described above, with funding to be increased based upon the Implicit Price Deflator.

In SFY 2004, 2,932 individuals received treatment under CJTA.

In State Fiscal Year 2004, Alcohol was the Primary Substance of Abuse for the Majority of Individuals in Treatment Under the Criminal Justice Treatment Account.

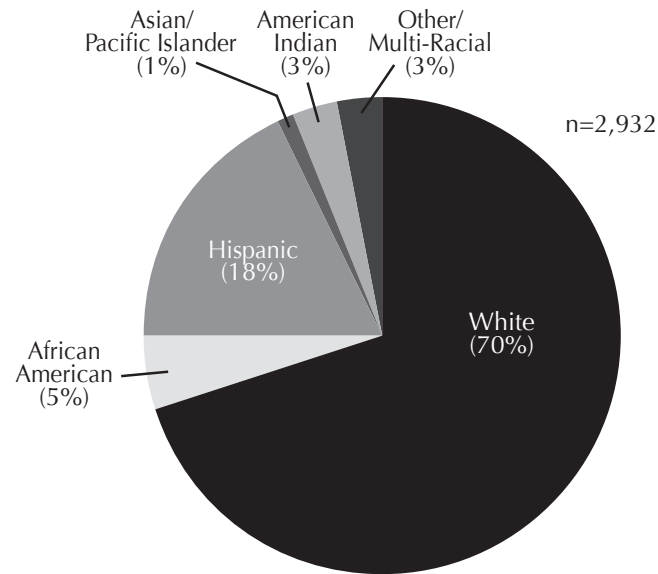


Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance, Department of Social and Health Services.

In SFY 2004, alcohol was the primary substance of abuse for individuals in treatment under the Criminal Justice Treatment Account (CJTA). Both in Washington and nationally, alcohol remains the single largest cause of mortality-, crime-, and health-related costs among all substances of abuse.

Beginning in SFY 2006, \$8,250,000 is being transferred annually into the CJTA for judicially supervised treatment and treatment support services in lieu of incarceration.

In State Fiscal Year 2004, 30% of Those Receiving Treatment under the Criminal Justice Treatment Account were Racial and Ethnic Minorities.



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance, Department of Social and Health Services.

In SFY 2004, racial and ethnic minorities comprised 30% of those receiving treatment under the Criminal Justice Treatment Account. Some 71% were male, 29% female. The median age was between 30 and 35.

Beginning in SFY 2006, \$8,250,000 is being transferred annually into the CJTA for judicially supervised treatment and treatment support services in lieu of incarceration.

Treatment Through the Department of Corrections





The Washington State Department of Corrections Responds to the Need for Chemical Dependency Treatment.

Over the past decade, the need for quality chemical dependency treatment among inmates in the custody of the Washington State Department of Corrections (DOC) has become increasingly apparent. More than one in five inmates in DOC custody – in prisons, pre-release facilities, and work release – was convicted of drug offenses, making drug crimes the single largest category of offenses. Of the 8,785 inmates admitted to DOC custody and screened in SFY 2004, 4,470, representing 51%, were found to be chemically dependent.¹

Responding to this need, DOC provides a multi-phased continuum of care which includes: screening; diagnostic assessment; intensive primary treatment; coordinated transition and case management; outpatient treatment; and referral to community-based treatment. All 37 DOC treatment sites are certified by the Division of Alcohol and Substance Abuse, and employ offender-specific, research-based best practices. The goal of these programs is to reduce reoffense, enhance the safety of communities, and prepare offenders for more productive lives once they are released.

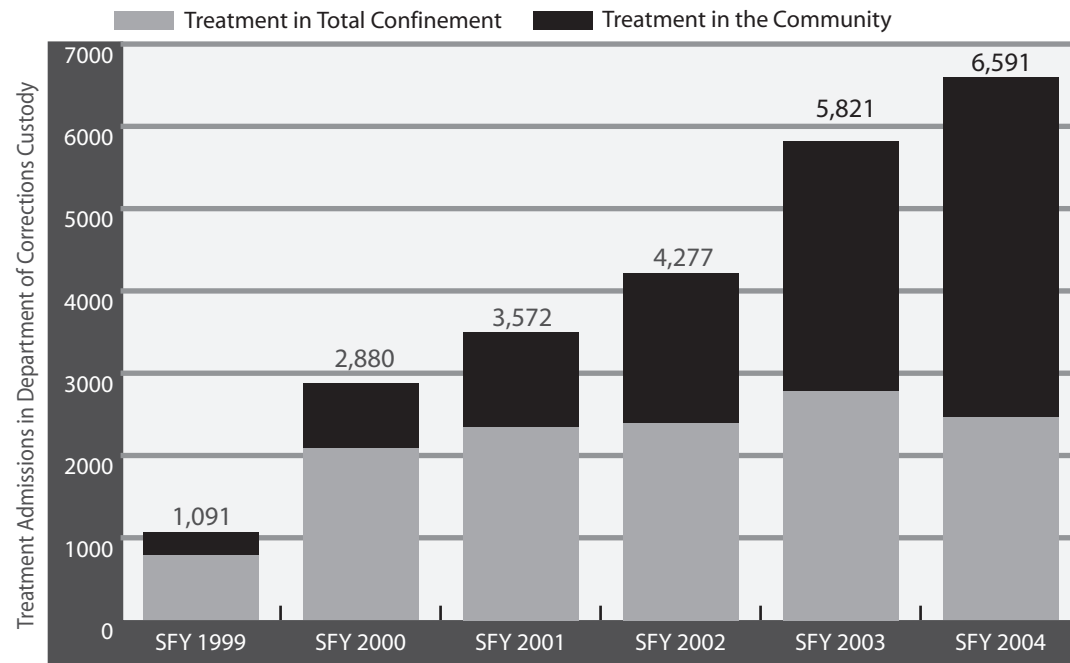
DOC provides two primary treatment modalities:

- **Modified Residential Therapeutic Community (TC)** – TC is a progressive, phased program of care, 9-12 months in length. Through modified TC, patients are provided a separate living area and a highly structured treatment environment, including traditional chemical dependency treatment coupled with emphasis upon “right living” and personal accountability. Services are delivered by a multi-disciplinary team. Development and demonstration of specific behaviors are required prior to transition to further program phases.
- **Intensive Outpatient (IOP)** – Within DOC, IOP is a highly structured intervention delivered in total and partial confinement as well as in the community. IOP is offered in varying lengths-of-stay in order to conform to the sentence structure and meet the needs of offenders in different institutions and in the community.

Following completion of a primary level of treatment, offenders are admitted to outpatient treatment. Based on the offender’s clinical progress, outpatient treatment continues as needed, with a minimum of three months occurring upon release from total confinement. In geographic areas, where DOC does not provide treatment, offenders may be referred to other contracted chemical dependency providers for appropriate services.

¹ Washington State Department of Corrections, July 2005.

Washington State Has Made a Major Commitment to Providing Chemical Dependency Treatment to Offenders in Total Confinement and Community Custody.



Source: Washington State Department of Corrections, July 2005.

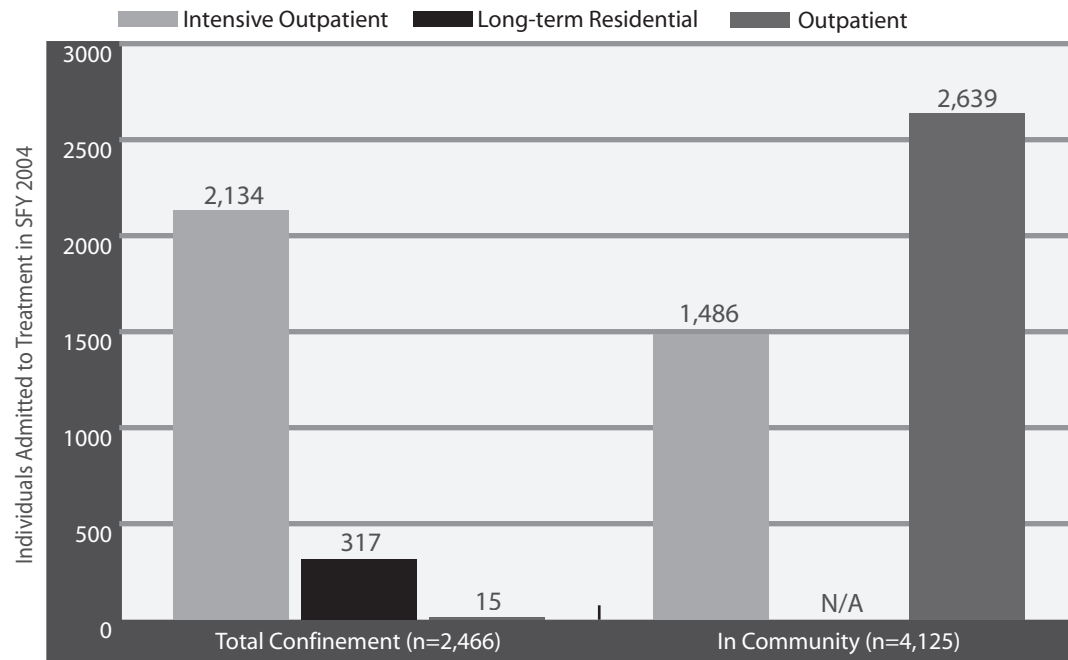
This graph indicates the depth of commitment Washington State has made in recent years toward the provision of alcohol and drug treatment services to offenders in the state correctional system. Especially noteworthy is the expansion of services to offenders in community custody. Admissions to treatment in the community now represent 63% of total admissions.

Consistent with best practices, offenders are admitted to treatment as close to release from total confinement as possible. Based on an offender's clinical progress while in confinement, outpatient treatment may continue as needed, with a minimum of three months of treatment occurring after release.



The Majority of Individuals Admitted to Chemical Dependency Treatment in the State Correctional System Receive Intensive Outpatient Treatment.

Offenders in Department of Corrections Custody Admitted to Treatment in SFY 2004



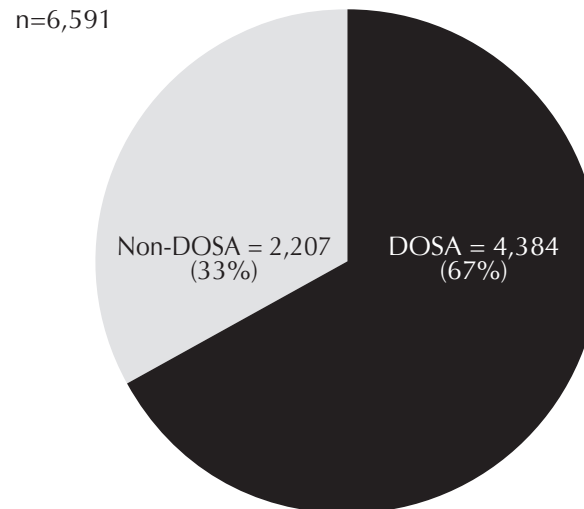
Source: Washington State Department of Corrections, July 2005.

The Washington State Department of Corrections offers three levels of chemical dependency treatment to offenders in custody who are assessed as in need. Long-term residential treatment is delivered in modified therapeutic communities, providing a highly structured living and treatment environment. Intensive outpatient treatment is provided both in correctional facilities and in communities in the form of highly structured interventions. Outpatient treatment, both in correctional facilities and in the community, follows completion of other primary levels of treatment. A minimum of three months of outpatient treatment is provided in the community, once an individual leaves total confinement.

Two Thirds of Individuals Receiving Chemical Dependency Treatment in the State Correctional System are Sentenced Under the Drug Offender Sentencing Alternative (DOSA).



Offenders in Department of Corrections Custody Admitted to Treatment in SFY 2004



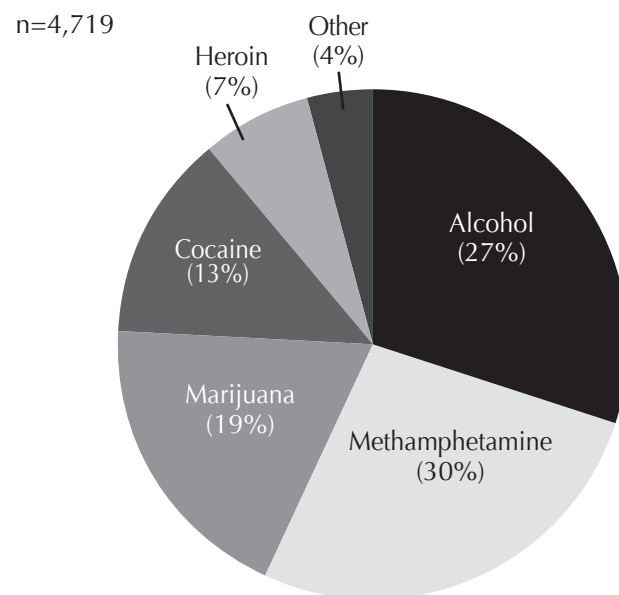
Source: Washington State Department of Corrections, July 2005.

The Drug Offender Sentencing Alternative (DOSA) provides judges with the option of ensuring those offenders who: A) pose a moderate to high risk of reoffense; B) pose a risk to public safety; and C) have had their lives disrupted due to substance abuse problems may receive chemical dependency treatment through the Department of Corrections. To qualify, offenders must have no current or prior sex or violent offenses and must not have used a deadly weapon in the commission of the offense. Additionally, if the offense was a violation of the Uniform Controlled Substance Act, the offense must have involved only a small quantity of illicit drugs.

Under DOSA, the offender serves one half of the mid-point of the standard sentencing range for the offense in total confinement, with the remainder of the term to be served in community custody. During incarceration, offenders undergo a comprehensive substance abuse assessment and receive appropriate treatment services. Services continue when the offender is released into community custody. Failure to meet conditions of the sentence – which can include drug testing and monitoring, and education or employment training – can result in imposition of the balance of the original sentence.



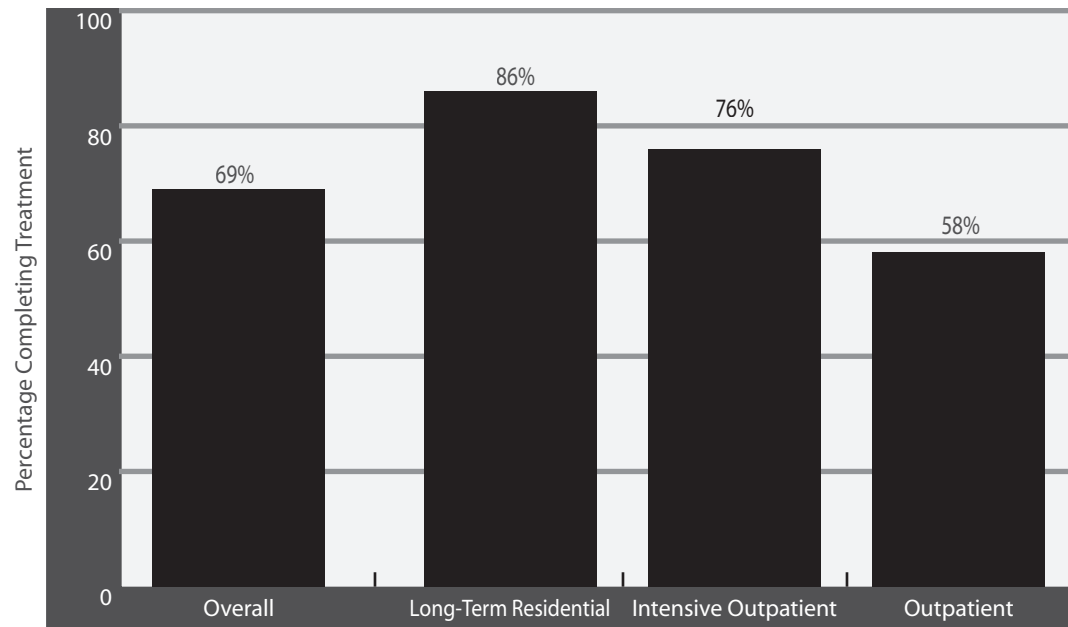
In SFY 2004, Methamphetamine and Alcohol were the Primary Drugs of Abuse of Individuals Assessed By the Department of Corrections.



Source: Washington State Department of Corrections, July 2005.

Of the 4,719 individuals assessed by the Department of Corrections in SFY 2004, 4,281 (90.7%) were found to be chemically dependent. More than half of those admitted to total confinement were in need of treatment.

In SFY 2004, the Completion Rate for Those Receiving Chemical Dependency Treatment Through the Department of Corrections was 69%.



Source: Washington State Department of Corrections, July 2005.

More than two thirds of those receiving chemical dependency treatment through the Department of Corrections complete it. For those who receive treatment through the Drug Offenses Sentencing Alternative (DOSA), the completion rate is 82%. Treatment completion is considered an important measure for inmates re-entering the community from incarceration, and should be associated with reduced criminal recidivism.

Outcomes: The Benefits of Prevention & Treatment

**TREATMENT
OUTCOMES
FOR:**

Adolescents

Pregnant Women

ADATSA Patients

Supplemental
Security Income
Recipients

Co-Occurring
Disorders
Patients

Individuals
Addicted to
Methamphetamine

Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction



The Work of the DASA Research and Evaluation Section

The Division of Alcohol and Substance Abuse's (DASA's) Research and Evaluation Section was created to respond to the need to demonstrate the effectiveness of substance abuse prevention and treatment in serving the overall mission of the Department of Social and Health Services (DSHS), "to improve the quality of life for individuals and families in need." Through research and evaluation activities, DASA is able to document the role of alcohol- and drug-related services in enhancing client self-sufficiency; protecting vulnerable adults, children, and families; and assuring public safety and helping to build strong, healthy communities. Research also aids in the development of "best practices" that can be utilized by chemical dependency treatment providers in improving the quality of care, and provides the scientific basis for the development of sound public policy.

DASA's productivity in research and evaluation is due, at least in part, to the strong partnership it has developed with the research community over the last decade. This is most evident in the 90-member Research Subcommittee of the Citizens Advisory Council on Alcoholism and Drug Addiction. Members are drawn from research institutions throughout the Northwest. DASA also coordinates a statewide "Bridging the Gaps" workgroup, which seeks to forge new partnerships among researchers, prevention and treatment providers, and policymakers.

Current Research Efforts

Some of the results of the outcomes research conducted under the auspices of DASA on the benefits of prevention and treatment are displayed on the following pages. Below is a partial list of research projects currently underway:

- Arrestee Drug Abuse Monitoring Project
- Evaluation of the Washington State Drug-Free Workplace Program
- Statewide Household Survey to Assess Need for Treatment Among Adults in Washington State
- Treatment Outcomes of Persons with Co-Occurring Mental Health and Substance Abuse Disorders
- Outcomes of Pregnant, Postpartum, and Parenting Women Who Receive Specialized Chemical Dependency Services
- Treatment Outcomes of Parenting Women Who Participate in Specialized and Non-Specialized Long-Term Care
- Analysis of Use, Cost, and Outcomes of Opiate Substitution Treatment Services in Washington and Oregon
- School Outcomes of Youth in Publicly Funded Treatment
- Cost Offsets of Treatment for Supplemental Security Income (SSI) Recipients
- Evaluation of the RUaD (Reduce Underage Drinking) Program

In addition, the Research and Evaluation Section is assisting in development of a web-based client outcome tracking system for use by providers, county coordinators, and state-level managers.

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Opiate Substitution
Treatment

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Profile of Adolescents Served in Publicly Funded Chemical Dependency Programs in Washington State

A profile of adolescents admitted to publicly funded treatment in Washington State in SFY 2004 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	5,503
<i>Median Age:</i>	15
<i>Gender:</i>	64% male; 36% female
<i>School Attendance:</i>	71% in school (at least part-time); 29% out of school
<i>Primary Drug:</i>	Marijuana - 64%; Alcohol -22%; Stimulants (including Methamphetamine) - 11%
<i>Criminal Justice Involvement:</i>	67% arrested at least once in previous year
<i>Housing Status:</i>	2% homeless*

A 1999 study of adolescents (age 20 and younger) receiving publicly funded chemical dependency treatment in Washington State revealed the following profile:

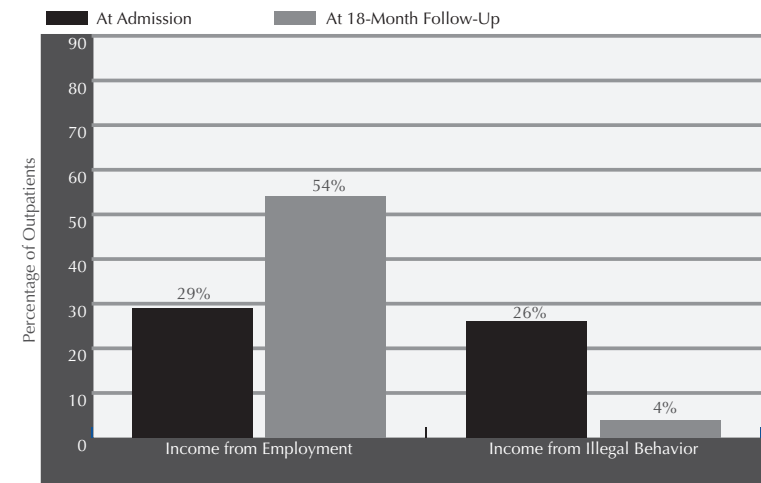
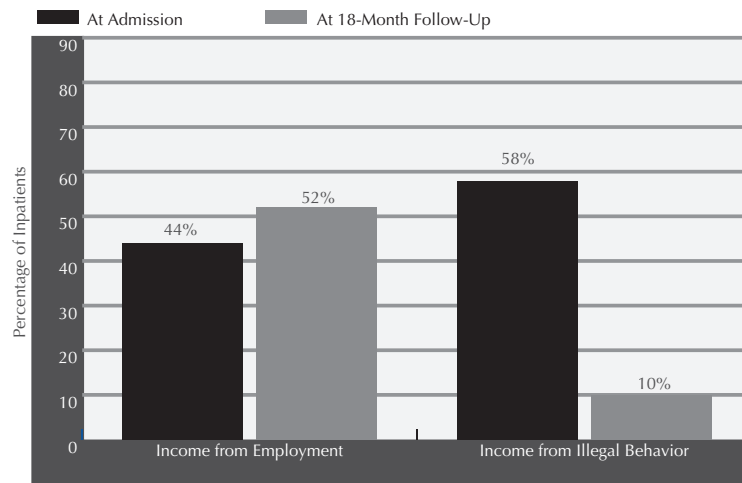
- Between 55-70% of youth admitted to residential treatment had run away from home at least once in their lives
- Between 23-34% of youth had one or more emergency room visits in the year prior to admission;
- 90% of youth admitted to treatment began using their primary substance of abuse prior to age 16;
- Between 70-90% reported at time of admission that they currently smoke cigarettes.
- Between 23-37% of those admitted to residential treatment had been domestic violence victims.²

*Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2005. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

² Rodriguez, F. *Profile of Youth Clients Admitted to Publicly Funded Substance Abuse Treatment Programs in Washington State, 1998*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

After Treatment, More Adolescents Reported Income Earned from Employment, and Fewer Reported Income Earned from Illegal Behavior.

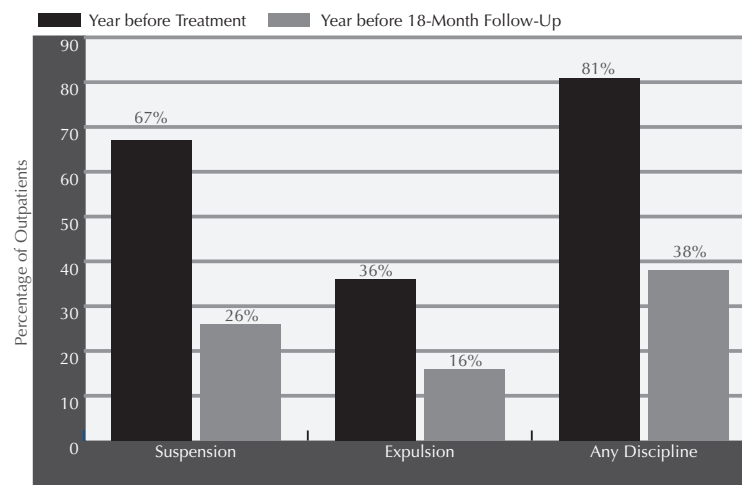
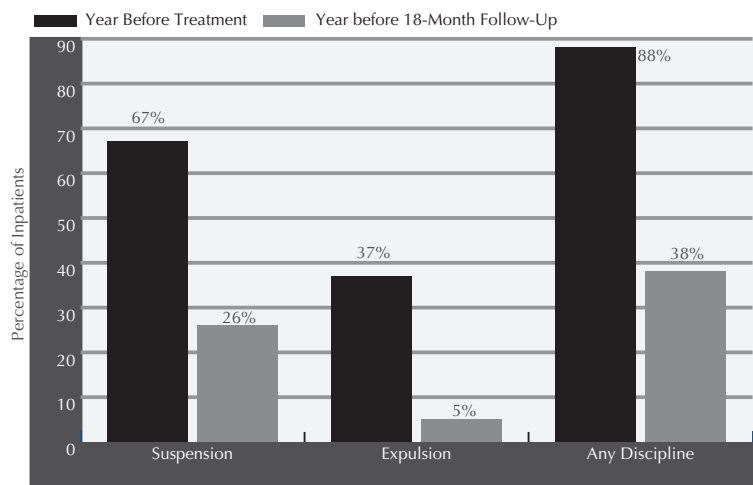


Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report*. St. Paul, MN: New Standards, Inc., 1997.

At the time of admission, adolescent inpatients were more likely to report income from illegal behavior than from legitimate employment, while outpatients were almost equally as likely to report income from both sources. At the time of the 18-month follow-up, however, adolescents who had been in either inpatient or outpatient treatment were five times more likely to report income from employment rather than illegal behavior. Substantial new funding is now being provided for the treatment of low-income youth under the Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005.



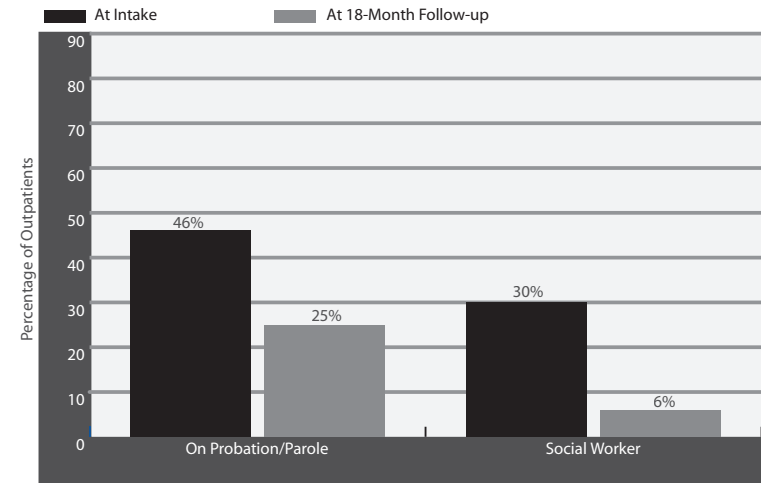
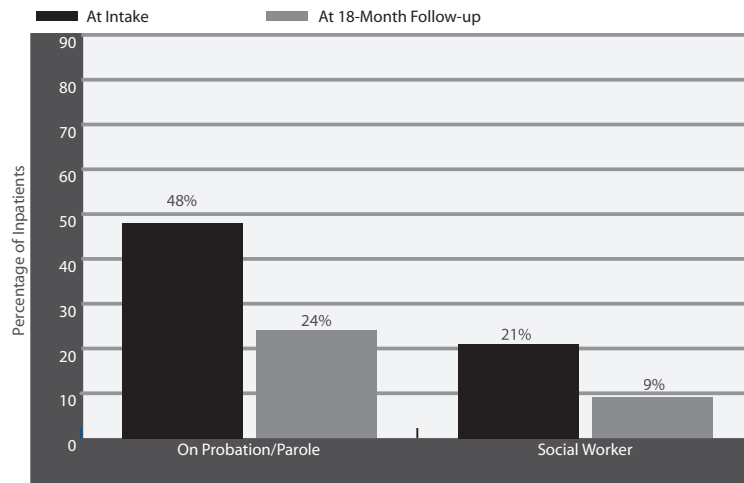
School Discipline Problems for Adolescent Patients Decreased After Treatment.



Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report*. St. Paul, MN: New Standards, Inc., 1997.

Not surprisingly, adolescents with substance abuse problems tend to experience behavioral problems when attending school. After substance abuse treatment, however, the number of adolescents reporting any school discipline problems in the preceding year dropped by 50%. An especially encouraging outcome is the substantial reduction in school expulsions for youth receiving either inpatient or outpatient treatment. Additional study results also showed a corresponding improvement in school grades after treatment. The Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005 provides substantial new funding for the treatment of low-income youth.

A Lower Percentage of Adolescent Patients were Under Legal Supervision 18 Months After Treatment.



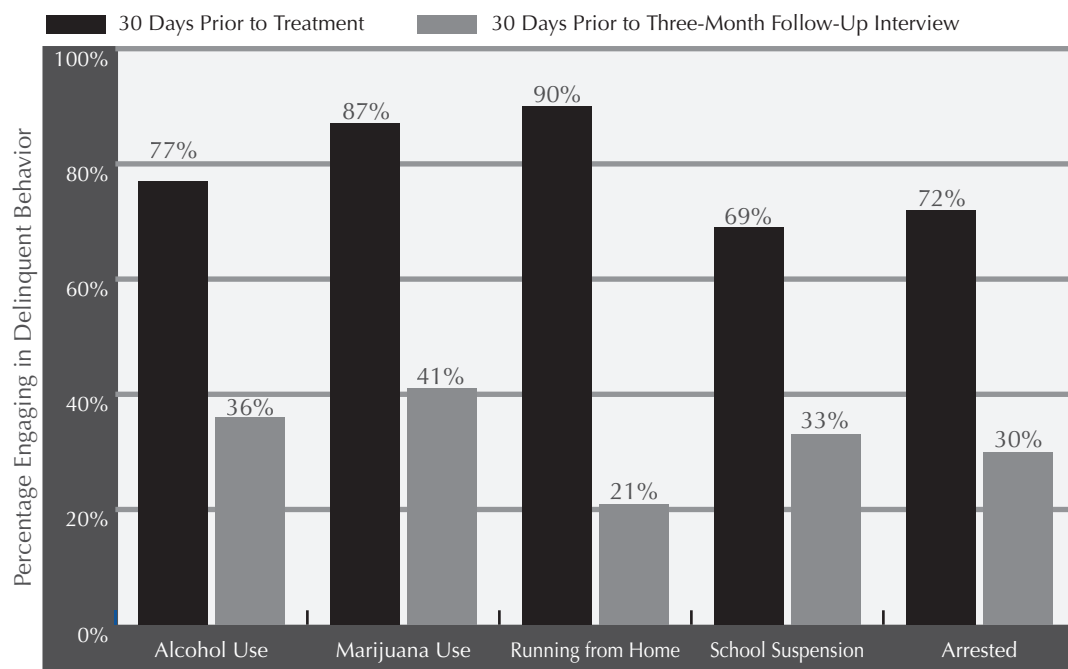
Source: New Standards, Inc. *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report*. St. Paul, MN: New Standards, Inc., 1997.

A large proportion of children involved in the juvenile justice system have substance abuse problems and, similarly, a large portion of juveniles in chemical dependency treatment programs are involved in criminal activities. Therefore, it is expected that obtaining substance abuse treatment will have a positive effect on criminal behavior, as well as decreasing or ceasing substance use.

As expected, legal involvement by adolescents decreased considerably after treatment for both inpatients and outpatients. Compared to their status at intake, approximately half as many adolescents were on parole or probation at the time of follow-up. There was a similar reduction in supervision by social workers for inpatients, and only 6% of outpatients were under a social worker's supervision at the 18-month follow-up, compared to 30% at intake.



“Becca” Youth Who Complete Residential Chemical Dependency Treatment Are Much Less Likely to Use Alcohol or Marijuana, Less Likely to Run Away from Home, and Less Likely to Be Suspended from School or Arrested.

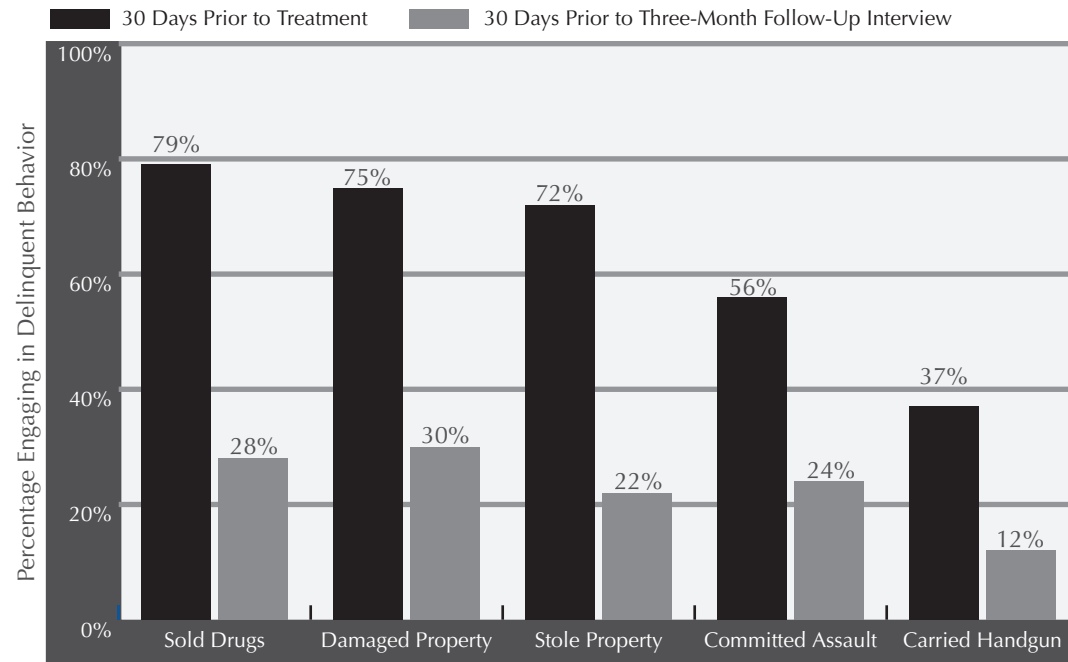


Source: Peterson, P., et al., *Treatment Outcome Evaluation: Youth Admitted to Residential Chemical Dependency Treatment Under the Provisions of the “Becca” Bill*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 1997.

The 1995 At-Risk/Runaway Youth Act created the “Becca” program, named after a youth who was murdered after she ran away from home. Becca youth are chemically dependent adolescents who are beyond their parent’s control and/or are chronic runaways. These youth are estimated at approximately 3-4% (1,350 to 2,250) of the 45,000 youth ages 13-19 who are in need of substance abuse treatment. Most are ages 14 to 16.

While the needs of Becca Youth are very high, this graph indicates that residential chemical dependency treatment results in significant positive changes in behavior following treatment completion. Substantial new funding is now being provided for the treatment of low-income youth under the Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005.

Rates of Delinquent Behavior Among “Becca” Youth Decline Substantially Following Completion of Residential Chemical Dependency Treatment.



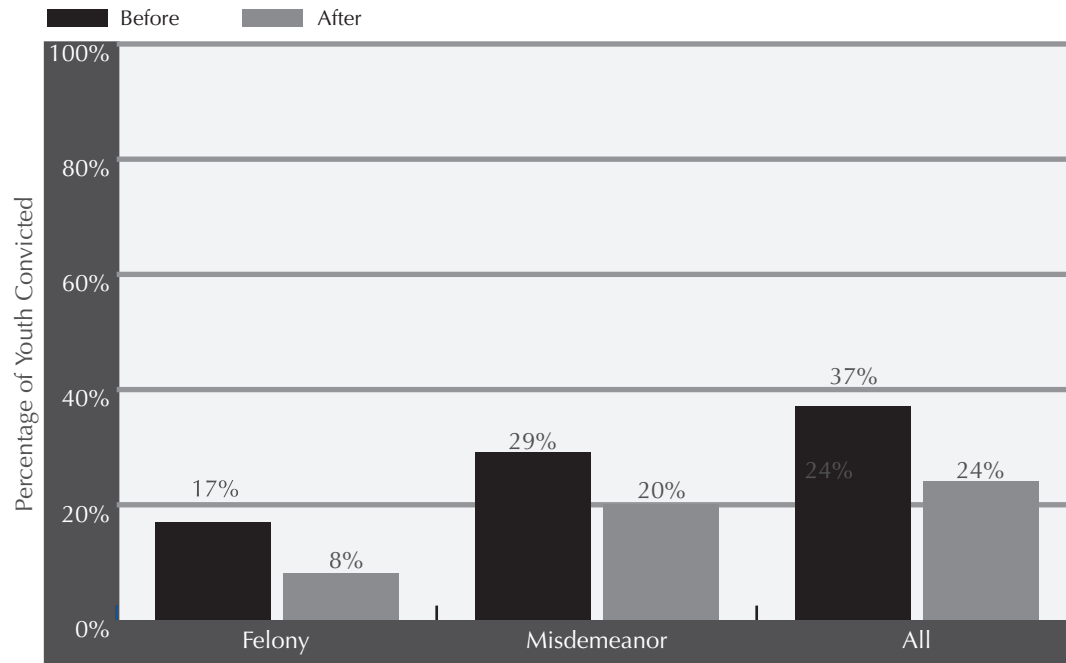
Source: Peterson, P., et al., *Treatment Outcome Evaluation: Youth Admitted to Residential Chemical Dependency Treatment Under the Provisions of the “Becca” Bill*. Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 1997.

This graph indicates that Becca youth who receive chemical dependency treatment are much less likely to engage in delinquent behavior following treatment completion. In this 1997 study conducted by the University of Washington, the percentage of Becca youth involved in selling drugs declined by 64.6%; those stealing property dropped by 60.4%; and the percentage of those who committed assault dropped by 57.1%.

The 1995 At-Risk/Runaway Youth Act created the “Becca” program, named after a youth who was murdered after she ran away from home. Becca youth are chemically dependent adolescents who are beyond their parent’s control and/or are chronic runaways. These youth are estimated at approximately 3-4% of youth ages 13-19 who are in need of substance abuse treatment. Most are ages 14-16.



There are Significant Declines in Criminal Convictions Among Youth Who Receive Chemical Dependency Treatment.



Source: Luchansky, B., et al., "Treatment Readmissions and Criminal Recidivism in Youth Following Participation in Chemical Dependency Treatment." Olympia, WA: Washington State Department of Social and Health Services, 2003.

A 2003 study of almost 6,000 Washington State youth ages 14-17 found significant declines in criminal convictions following chemical dependency treatment. The rate of all convictions fell from 37% in the 18 months prior to treatment to 24% in the 18 months following treatment, representing a 35% decline. Felony convictions declined by 56%; misdemeanors fell by 30%.

However, waiting lists for publicly funded chemical dependency treatment for youth remain very long. Average wait time for youth residential treatment in April 2004 was approximately 4-6 weeks.

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Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction



Profile of Pregnant Women Served in Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of pregnant women admitted to publicly funded treatment in Washington State in SFY 2004 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	584
<i>Median Age:</i>	23
<i>Employment Status:</i>	Employed (full- or part-time) – 7%; Unemployed – 93%
<i>Primary Drug:</i>	Stimulants (including Methamphetamine) - 35%; Alcohol – 20%; Marijuana - 22%
<i>Criminal Justice Involvement:</i>	53% arrested at least once in previous year
<i>% with Children in the Home:</i>	37%
<i>Housing Status:</i>	10% homeless*

A 1999 study of pregnant, post-partum, and/or parenting women (PPWs) admitted to publicly funded chemical dependency treatment in Washington State indicated:

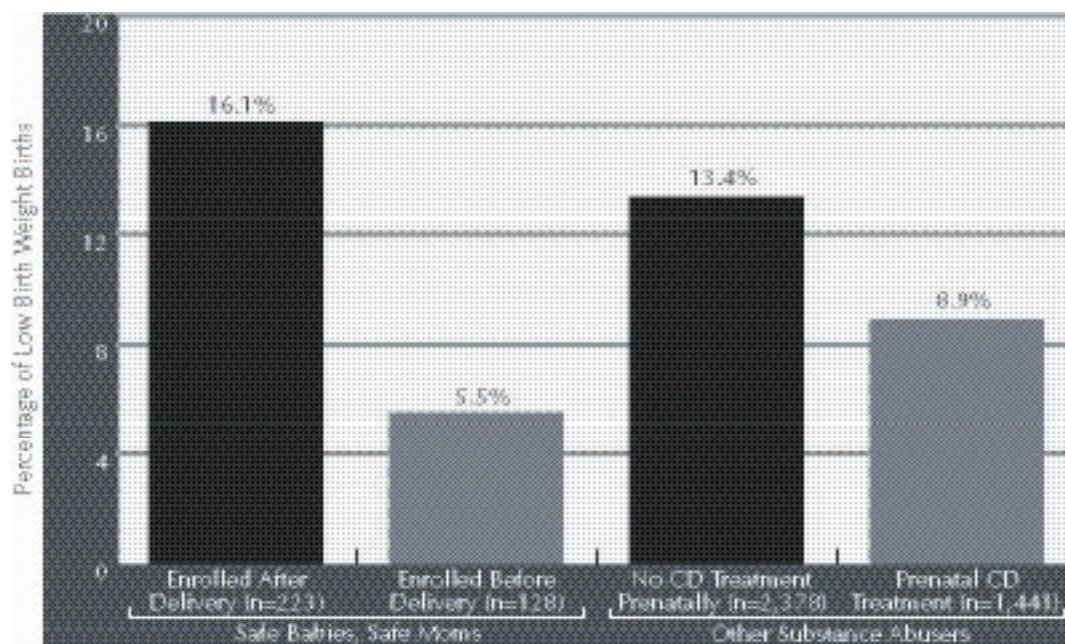
- More than 60% of PPWs admitted to treatment had been victims of domestic violence;
- Over 50% reported public assistance as their primary source of income;
- Over one quarter reported having received mental health treatment in the year prior to admission.²

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

¹ Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2005. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

² Rodriquez, F., *Profile of Pregnant, Post-Partum, and/or Parenting Women (PPWs) Admitted to Publicly Funded Substance Abuse Treatment Programs in Washington State, 1998*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

Substance-Abusing Women Who Received Chemical Dependency Treatment were Less Likely to Have a Low Birth Weight Baby.



Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Low birth weight (LBW) – newborn infants weighing less than 5.5 pounds, or 2,500 grams—is the risk factor most closely associated with neonatal death, and is associated with a wide range of disorders, including neurodevelopmental conditions, mental retardation, vision and hearing impairments, and other developmental disabilities. Alcohol and other drug abuse is linked to LBW.¹

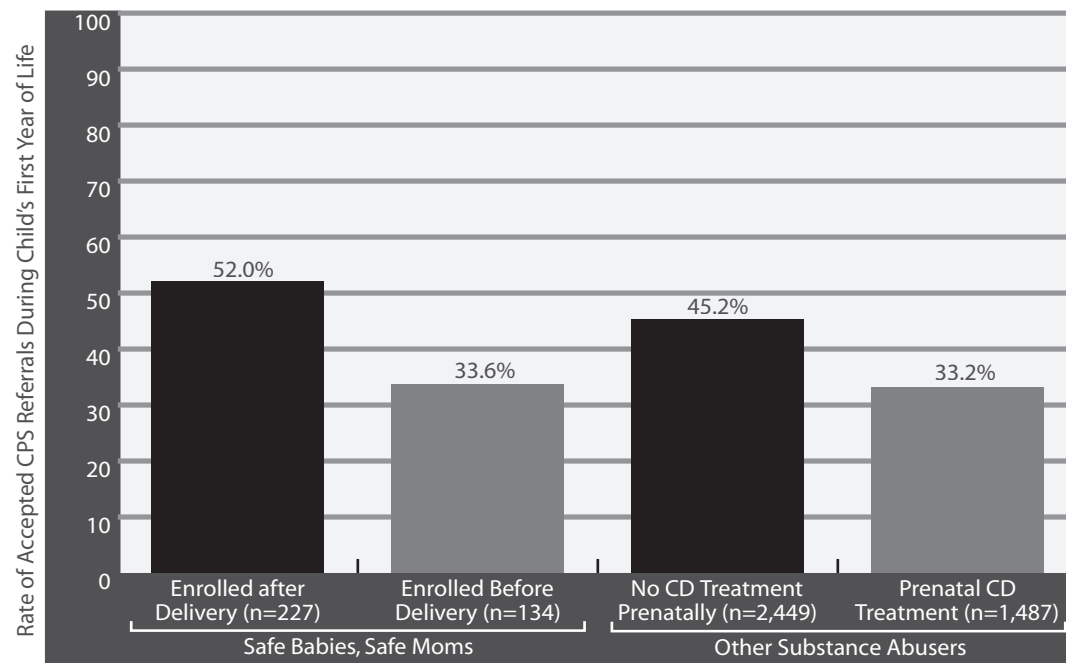
Substance-abusing pregnant mothers receiving comprehensive services, including chemical dependency treatment, through the Safe Babies, Safe Moms program, were 66% less likely to give birth to an LBW baby, compared with substance-abusing women who enroll after delivery. Outside of the program, substance-abusing women who received chemical dependency treatment prenatally were 34% less likely to give birth to an LBW baby, compared with women who did not receive treatment.²

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4, 5, 34. Washington, DC: 2000.

² Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.



Substance-Abusing Women Who Received Chemical Dependency Treatment Prenatally were Less Likely to Be Referred Later to Child Protective Services.



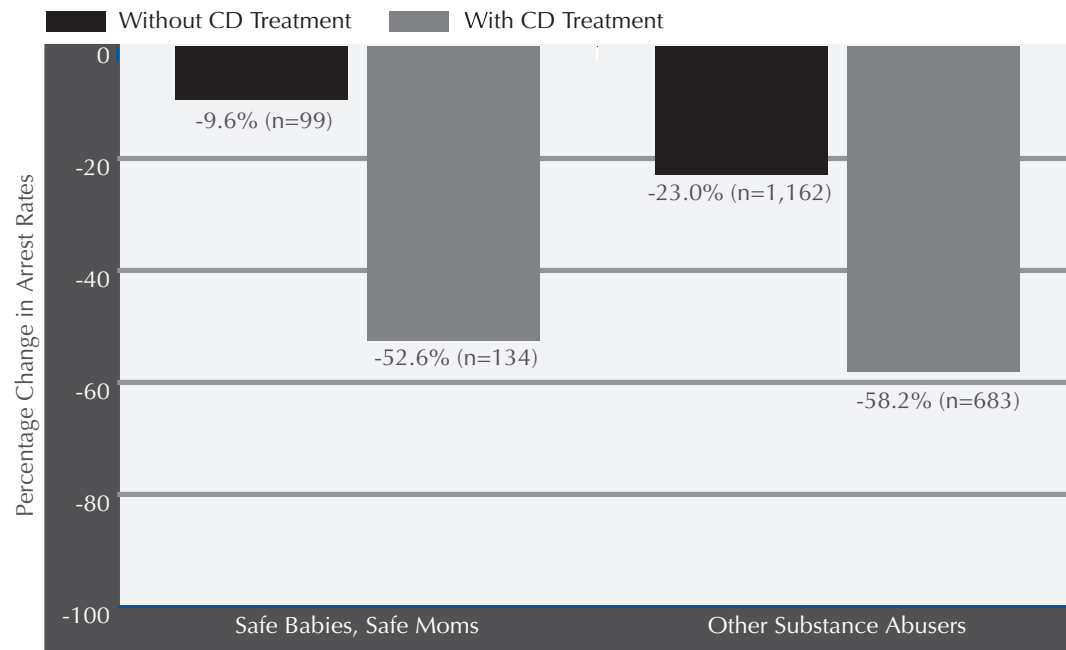
Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Child abuse and neglect is one of the most important consequences of maternal substance abuse. The rate of accepted referrals to Child Protective Services (CPS) during a child's first year of life is ten times higher (45.2%) when their substance-abusing mothers did not receive chemical dependency treatment than for infants on Medicaid whose mothers are not substance abusers (4.5%).

Substance-abusing pregnant mothers receiving comprehensive services, including chemical dependency treatment prenatally, through the Safe Babies, Safe Moms program, were 35.4% less likely to be referred to CPS during the first year of their child's life than those enrolling after their child was born. Outside of the program, substance-abusing women who received chemical dependency treatment prenatally were 26.5% less likely to be referred to CPS during the first year of their child's life than substance-abusing women who did not receive treatment.¹

¹ Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Substance-Abusing Pregnant Women Who Received Chemical Dependency Treatment were Less Likely to Be Arrested.



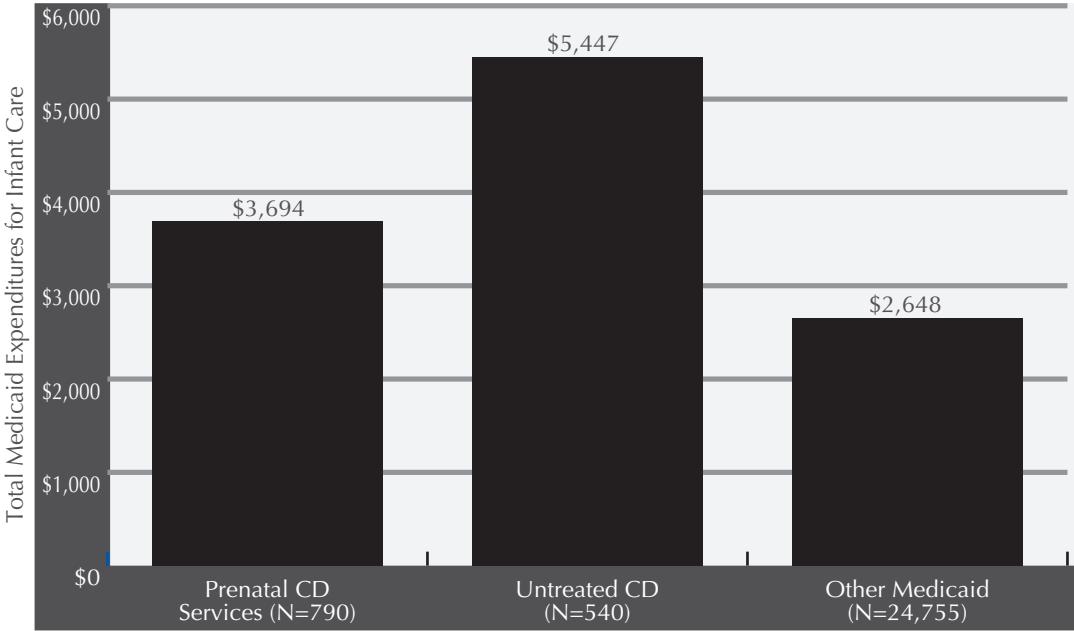
Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Criminal justice involvement is a significant issue for many pregnant, substance-abusing women. In addition to the burden of drug- and alcohol-related crime on society, crime presents serious health and developmental risks to children, both prenatally and after they are born.

Among women enrolled in the Safe Babies, Safe Moms program, those who received chemical dependency treatment had more than a five times greater reduction in arrest rates in the following two years compared with those who did not receive treatment. Outside of the program, among substance-abusing pregnant women, those who received chemical dependency treatment had more than double the reduction in arrest rates in the following two years after delivery compared with those who did not receive treatment.¹

¹ Cawthon, L. "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Average Medicaid Costs During the First Two Years of Life were Lower for Infants Born to Women Who Received Chemical Dependency Treatment in the Prenatal Period than for Those Born to Substance-Abusing Women Who Did Not Receive Treatment.



Source: Cawthon, L., & Schrager, L., "Substance Abuse Treatment and Birth Outcomes for Pregnant and Postpartum Women in Washington State." *First Steps Database 5(1)*. Washington State Department of Social and Health Services, 1995.

Low birth weight (LBW – newborn infants weighing less than 5.5 pounds, or 2,500 grams) is the single most important factor in determining infant medical care expenditures during the neonatal period. Alcohol and other drug use is associated with LBW.¹

This graph indicates that average Medicaid expenditures for care during the first two years of life for infants born to untreated substance abusers was 47.5% higher than for substance-abusing women who received chemical dependency treatment during pregnancy, and more than twice that for infants born to non-substance abusing women receiving Medicaid.

¹ U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4, 5, 34. Washington, DC: 2000.

Outcomes: The Benefits of Prevention & Treatment

**TREATMENT
OUTCOMES
FOR:**

Adolescents

Pregnant Women

ADATSA Patients

Supplemental
Security Income
Recipients

Co-Occurring
Disorders
Patients

Individuals
Addicted to
Methamphetamine

Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction



Profile of ADATSA Patients Receiving Publicly Funded Chemical Dependency Treatment in Washington State

A profile of patients admitted to publicly funded treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) in Washington State in SFY 2004 reveals the following characteristics at time of admission:¹

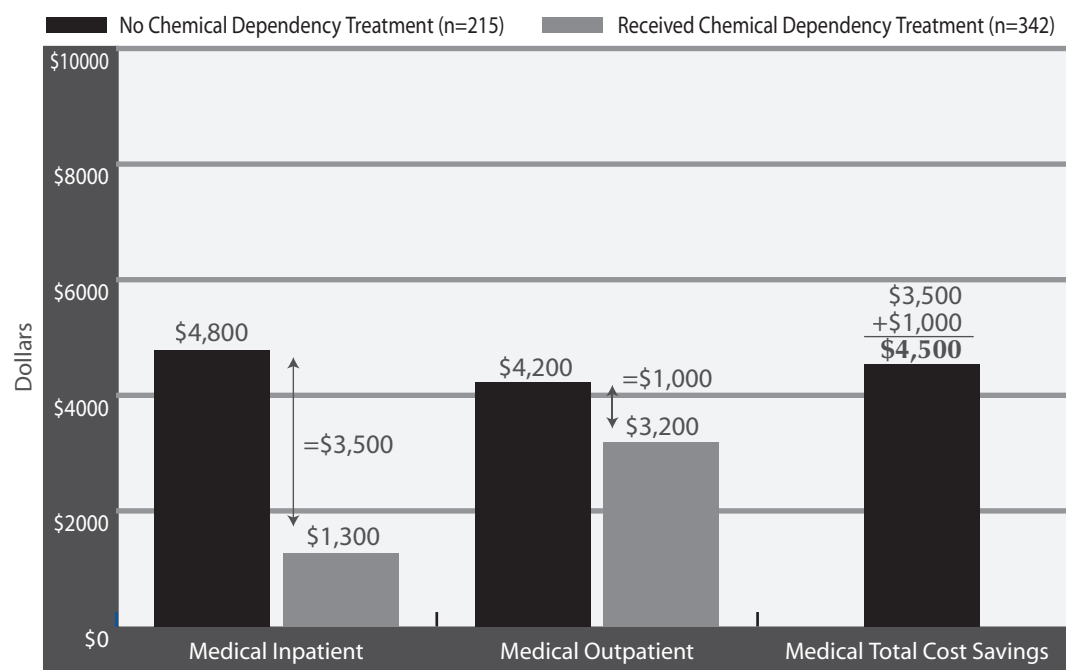
<i>Number of Individuals Admitted:</i>	7,583
<i>Median Age:</i>	35
<i>Gender:</i>	65% Male; 35% Female
<i>Employment Status:</i>	Employed (full- or part-time or temporary) – 3%; Unemployed – 97%
<i>Primary Drug:</i>	Alcohol – 45%; Stimulants (including Methamphetamine) – 25%; Marijuana - 13%; Cocaine/Crack – 12%
<i>Criminal Justice Involvement:</i>	64% arrested at least once in previous year
<i>% with Children in the Home:</i>	21%
<i>Housing Status:</i>	24% homeless*

Enacted in 1987, the ADATSA legislation created a program to treat adults addicted to alcohol or other drugs. To qualify, clients must be indigent, unemployable, and incapacitated due to their addiction. Patients may be admitted to either residential or outpatient treatment modalities as individually required. The immediate goal of the program is abstinence, while ancillary goals include improved personal coping skills, as well as social and vocational skills. Success is expected to result in patients moving toward a long-term objective of self-sufficiency.

*Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2005. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

Average Medical Costs for ADATSA Patients Who Received Chemical Dependency Treatment were \$4,500 Lower than Those for Untreated Patients Over a Five-Year Follow-Up Period.

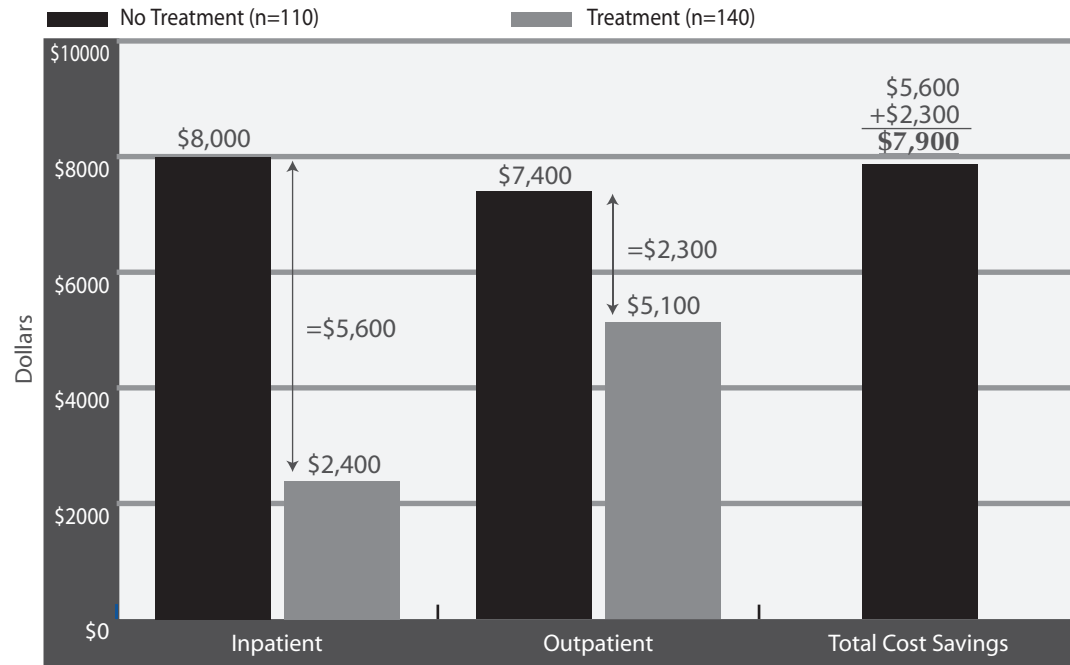


Source: Luchansky, B., & Longhi, D., *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1997.

This graph indicates that chemical dependency treatment can result in lower medical expenses. Over a five-year period, treated ADATSA patients had medical costs averaging \$4,500 less than those who did not receive treatment. Inpatient hospital expenses averaged \$3,500 less, while outpatient medical expenses averaged \$1,000 less.¹

¹ Luchansky, B., & Longhi, D. *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Service, Research and Data, Analysis, 1997.

For ADATSA Patients with Medicaid Medical Expenses Prior to Admission, Chemical Dependency Treatment was Associated with \$7,900 in Overall Savings in Medical Expenses Over a Five-Year Follow-Up Period.

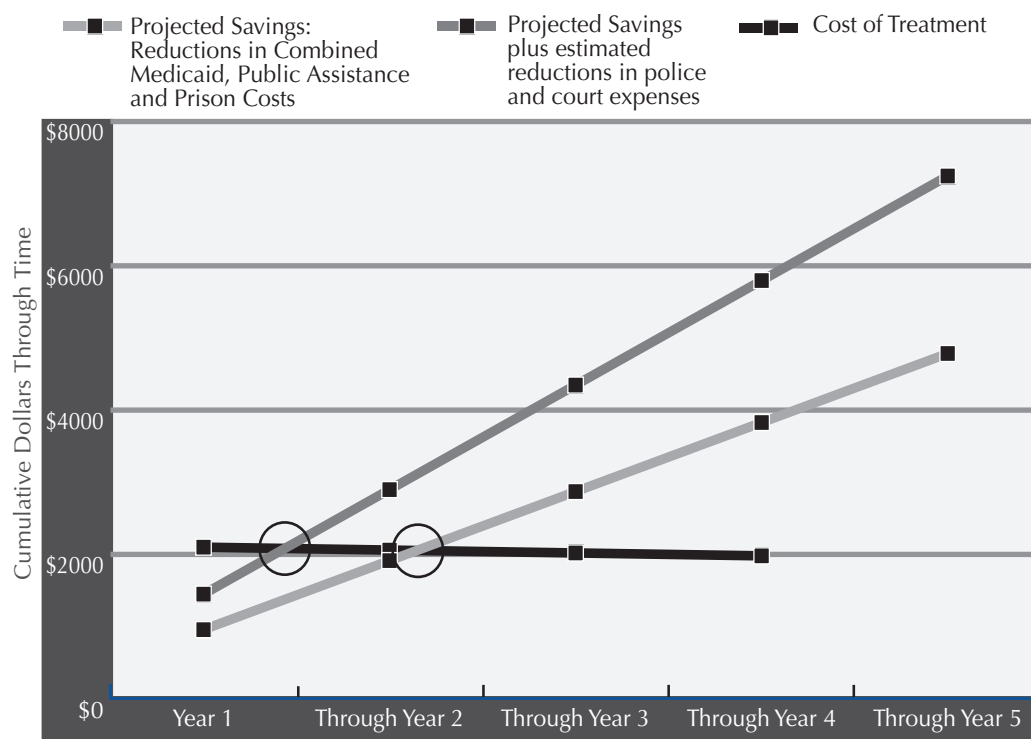


Source: Luchansky, B., & Longhi, D., *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1997.

This graph indicates striking savings in medical expenses for ADATSA patients, with Medicaid medical expenses prior to admission, in the five years following chemical dependency treatment. Overall savings totaled \$7,900 — \$2,300 in hospital inpatient, and \$5,600 in medical outpatient expenses.¹ Chemical dependency treatment is a wise investment, both in the health of ADATSA patients, and in reducing overall health expenses.

¹ Luchansky, B., & Longhi, D. *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Service, Research and Data, Analysis, 1997.

Chemical Dependency Treatment Provided to ADATSA Patients Results in Reduced Costs to the Public Over a Five-Year Follow-Up Period.



Source: Luchansky, B., & Longhi, D., *Cost Savings in Medicaid Expenses: An Outcome of Publicly Funded Chemical Dependency Treatment in Washington State: A Five-Year Cost Savings Study of Indigent Persons Served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1997.

This five-year comparison of projected incremental savings with projected treatment costs for ADATSA (Alcoholism and Drug Addiction Treatment and Support Act) patients shows that the overall incremental savings are \$7,200, while the cumulative treatment costs total \$1,940. This means that every additional dollar spent on the treatment group results in \$3.71 in savings by the end of the five-year period. When estimated reductions in police and court expenses are added to the projections, the break-even point between costs and savings occurs much sooner. Additional funds spent on treatment pay for themselves in just over one year.

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Profile of Supplemental Security Income (SSI) Recipients Receiving Publicly Funded Chemical Dependency Treatment in Washington State

Under the Supplemental Security Income (SSI) program, the federal government provides public assistance to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.

A profile of SSI recipients admitted to publicly funded chemical dependency treatment in Washington State in SFY 2004 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	2,515
<i>Median Age:</i>	40
<i>Gender:</i>	54% Male; 46% Female
<i>Employment Status:</i>	Employed (full- or part-time or temporary) – 3%; Unemployed – 97%
<i>Primary Drug:</i>	Alcohol – 45; Heroin – 17%; Marijuana – 12%
<i>Criminal Justice Involvement:</i>	56% arrested at least once in previous year
<i>% with Children in the Home:</i>	21%
<i>Housing Status:</i>	9% homeless*

*Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2005. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

Chemical Dependency Treatment Lowers Medical Costs and is Associated with Better Criminal Justice Outcomes Among Supplemental Security Income (SSI) Recipients.*



The Department of Social and Health Services' Research and Data Analysis Division examined medical and chemical dependency treatment records for nearly 129,000 adult Supplemental Security Income (SSI) recipients to determine need for and receipt of chemical dependency treatment services.¹ Some 16% were found to be in need of treatment, and, of these, 50% received chemical dependency treatment between July 1997 and December 2001.

Medical, mental health, and nursing home cost differences between those who received treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical expenses, and also subtracting costs of chemical dependency treatment (including detoxification), average monthly costs were \$252 higher per month for individuals who did not receive treatment than for those who received at least some treatment. The differential was even greater for those completing chemical dependency treatment.

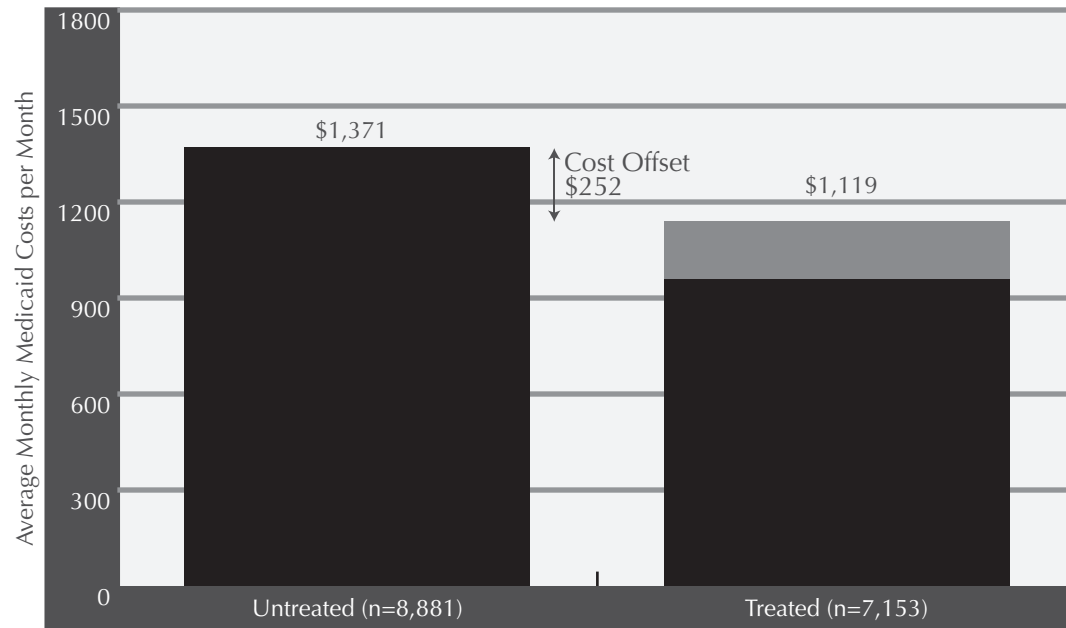
In addition, chemical dependency treatment for SSI recipients was associated with better criminal justice outcomes: for those who completed treatment, a 43% reduced likelihood of arrest; a 38% reduced likelihood of any conviction; and a 48% reduced likelihood of a felony conviction.

As a result of new funds made available with the enactment of the Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005, some 11,745 new Medicaid-eligible clients - a significant portion of whom are SSI recipients - will receive treatment during the 2005-2007 Biennium.

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*



Chemical Dependency Treatment is Associated with Significantly Lower Medical Costs Among Supplemental Security Income (SSI) Recipients.



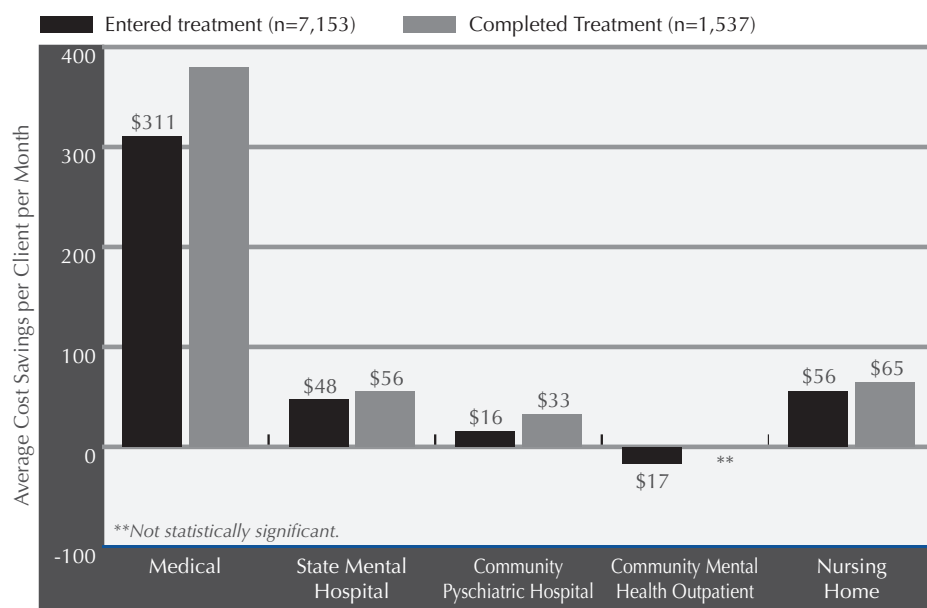
Source: Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Medical and chemical dependency treatment records for nearly 129,000 adult Supplemental Security Income (SSI) recipients were examined to determine the need for, and receipt of, chemical dependency treatment services. Of these recipients, 16% were in need of treatment, and 50% of those in need received treatment between July 1997 and December 2001.

Medicaid costs differences – including medical, mental health, and nursing home costs – between those who received chemical dependency treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical costs, the average monthly medical costs were \$414 per month higher for those who did not receive treatment. Even after including the cost of chemical dependency treatment, there was a net cost offset of \$252 per month or \$3,024 a year. The net cost offset rose to \$363 per month per client for those who completed treatment.¹

¹ Estee, S. & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Chemical Dependency Treatment is Associated with Significantly Lower Medical Costs Among Supplemental Security Income (SSI) Recipients.*



Source: Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

Medical and chemical dependency treatment records for nearly 129,000 adult Supplemental Security Income (SSI) recipients were examined to determine the need for, and receipt of, chemical dependency treatment services. Of these recipients, 16% were in need of treatment, and 50% of those in need received treatment between July 1997 and December 2001.

Medicaid costs differences – including medical, mental health, and nursing home costs – between those who received chemical dependency treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical costs, there were found to be significant savings in medical, mental health, and nursing home costs. Overall reductions were \$414 per month per client for those who entered chemical dependency treatment compared with those in need of treatment but who did not receive it, and even higher (\$530 per month) for those who completed treatment.¹

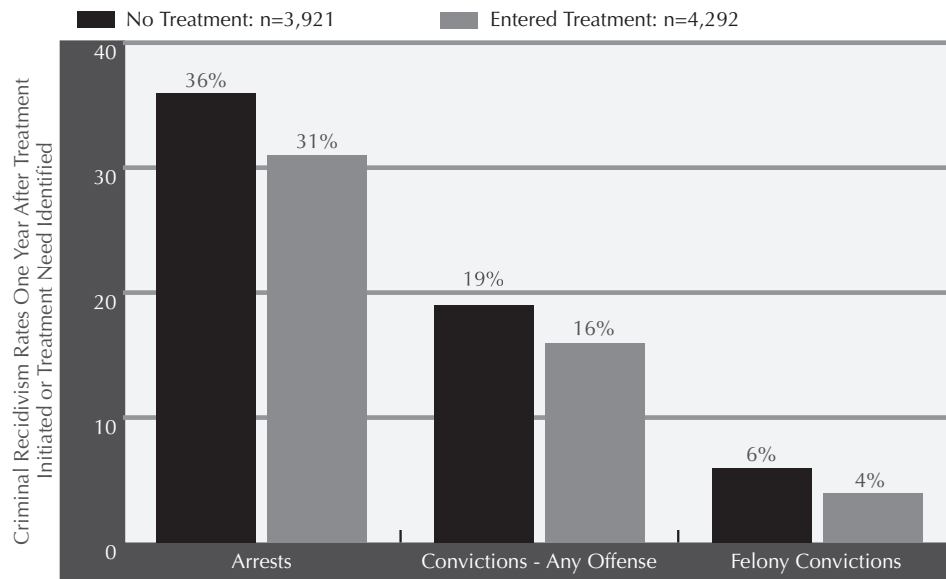
**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

¹ Estee, S. & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.



Chemical Dependency Treatment is Associated with Fewer Criminal Arrests and Convictions Among Supplemental Security Income (SSI) Recipients.*

Criminal Recidivism Rates One Year After Treatment Initiated or Treatment Need Identified



Source: Estee, S. and Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*. Washington Department of Social and Health Services, Research and Data Analysis Division, February 2003.

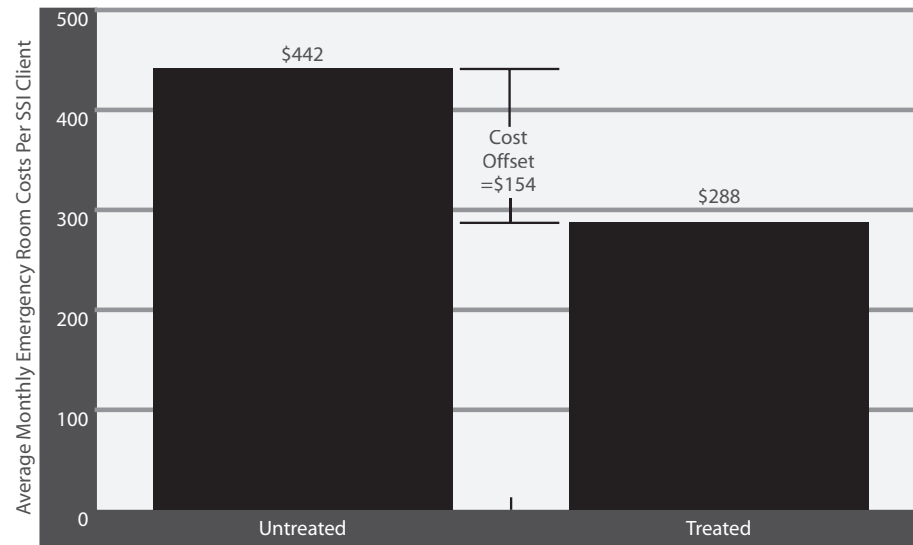
The Department of Social and Health Services' Research and Data Analysis Division examined criminal arrest and conviction and chemical dependency treatment records for nearly 129,000 adult Social Security Income (SSI) recipients.¹ Some 8,743 SSI recipients were found to have an arrest or conviction in the two years prior to initiating chemical dependency treatment or having a need for such treatment indicated. In the following year, those who entered treatment were found to be 16% less likely to have been arrested, and 34% less likely to have a felony conviction compared to those who did not enter treatment. Similarly, among clients who entered chemical dependency treatment and had a recent record of arrest or conviction, those who completed chemical dependency treatment were 43% less likely to be arrested, and 48% less likely to be convicted of a felony.²

*Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.

¹ Estee, S. and Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*. Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2003.

² Percentages are based on multivariate proportional hazards models that take account of age, gender, and race/ethnicity. See *Ibid.*, pp. 31-35 for details.

Savings in Emergency Room Costs Associated with Chemical Dependency Treatment Provided to Supplemental Security Income (SSI) Recipients More Than Offsets the Cost of Treatment.*



Source: Nordlund, D., et al., "Chemical Dependency Treatment Reduces Emergency Room Costs and Visits: Washington State Supplemental Security Recipients." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

In a study of almost 124,000 Supplement Security Income (SSI) recipients between July 1997 and December 2001, it was found that average monthly emergency room costs for those who were in need of chemical dependency treatment and received it were \$154 lower than for those who needed treatment but did not receive it. The number of visits per year was 19% lower, and average cost per visit was 29% lower. The saving in emergency room costs alone almost offset the average monthly cost of chemical dependency treatment (\$162).

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

Outcomes: The Benefits of Prevention & Treatment

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Disorders
Patients**

Individuals
Addicted to
Methamphetamine

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Patients

Patients Receiving
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Treatment

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Profile of Co-Occurring Patients Served in Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of patients with co-occurring mental health and chemical dependency admitted to publicly funded treatment in Washington State in SFY 2004 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	5,065
<i>Median Age:</i>	38
<i>Gender:</i>	49% Male; 51% Female
<i>Employment Status:</i>	Employed (full- or part-time or temporary) – 7%; Unemployed – 93%
<i>Primary Drug:</i>	Alcohol – 43%; Heroin – 19%; Marijuana – 13%
<i>Criminal Justice Involvement:</i>	57% arrested at least once in previous year
<i>% with Children in the Home:</i>	27%
<i>Housing Status:</i>	14% homeless*

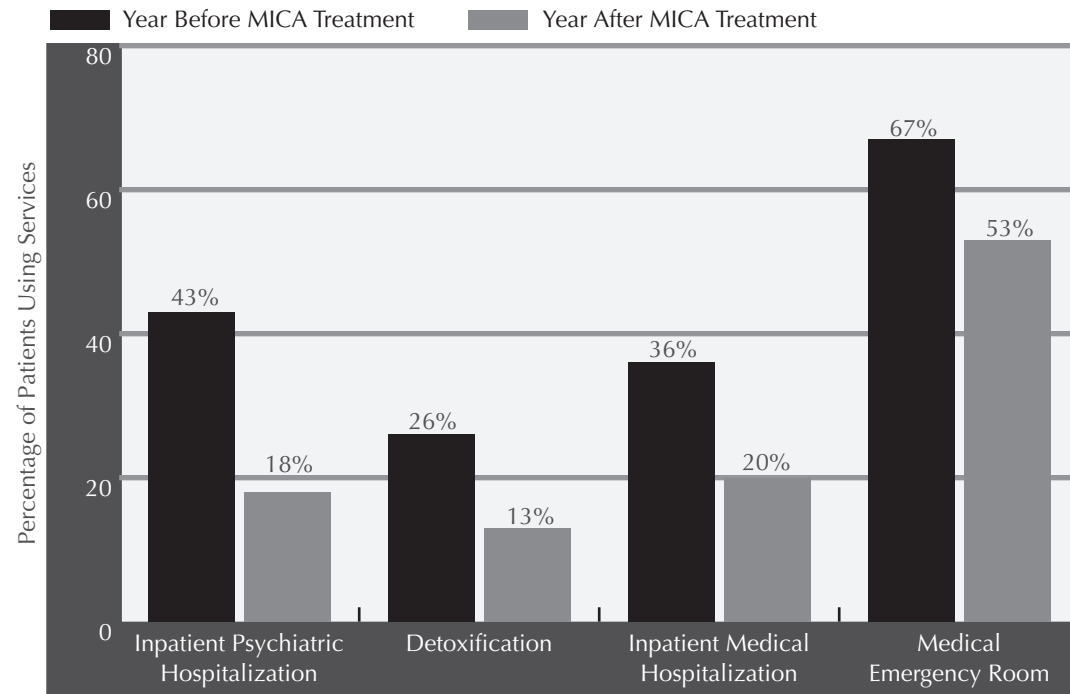
Data from the Division of Alcohol and Substance Abuse's TARGET system indicate that 19.4% of admissions to publicly funded chemical dependency treatment in SFY 2004 were for patients with co-occurring mental health problems. Some 2.0% are considered seriously mentally ill, having spent 15 or more days in a psychiatric hospital in the previous year.

Compared with individuals without co-occurring mental health problems who receive DASA-funded treatment services, co-occurring patients are: older; more likely to be female; less likely to be employed at time of admission; less likely to have alcohol as their primary substance of abuse; less likely to have been arrested in the previous year; and less likely to have children in their home.

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

¹ Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2005. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded. Co-occurring patients are defined as those who were received a mental health evaluation, with results revealing a positive indication for a mental health problem.

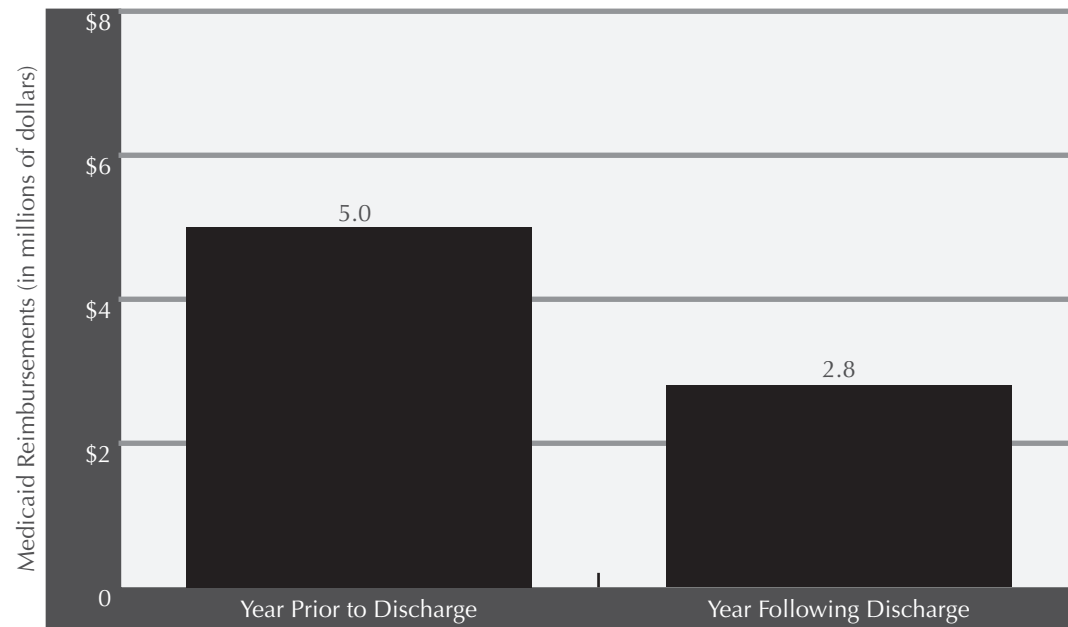
Patients with Co-Occurring Mental Health and Chemical Dependency Disorders Utilize Fewer Medicaid Services Following Discharge from Residential Treatment.



Source: Maynard, C., et al., "Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services & Research* 26(2), May 1999.

A significant number of Medicaid patients are diagnosed with both mental health and chemical dependency disorders. Treating these co-occurring disorders in an integrated manner has proven effective in enhancing health-related outcomes. Medicaid expenses for patients with co-occurring disorders receiving coordinated services in a residential chemical dependency treatment program decreased by 44% in the year following discharge from the year prior to treatment.

Use of Expensive Acute Care Services Decreased for Patients with Co-Occurring Mental Health and Chemical Dependency Disorders Following Discharge from Residential Treatment.



Source: Maynard, C., et al., "Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services & Research* 26(2), May 1999.

Integrated treatment for mental health and chemical dependency disorders has proven effective in reducing use of acute care services. In the year following discharge from residential chemical dependency treatment programs that provided integrated treatment for co-occurring disorders, the percentage of patients requiring psychiatric hospitalization fell by 58%; detoxification by 50%; medical hospitalization by 44%; and use of emergency rooms by 21%.

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Profile of Adults Receiving Publicly Funded Chemical Dependency Treatment for Methamphetamine Addiction in Washington State

A profile of adults admitted to publicly funded chemical dependency treatment with methamphetamine as their primary substance of abuse in Washington State in SFY 2004 reveals the following characteristics at time of admission:¹

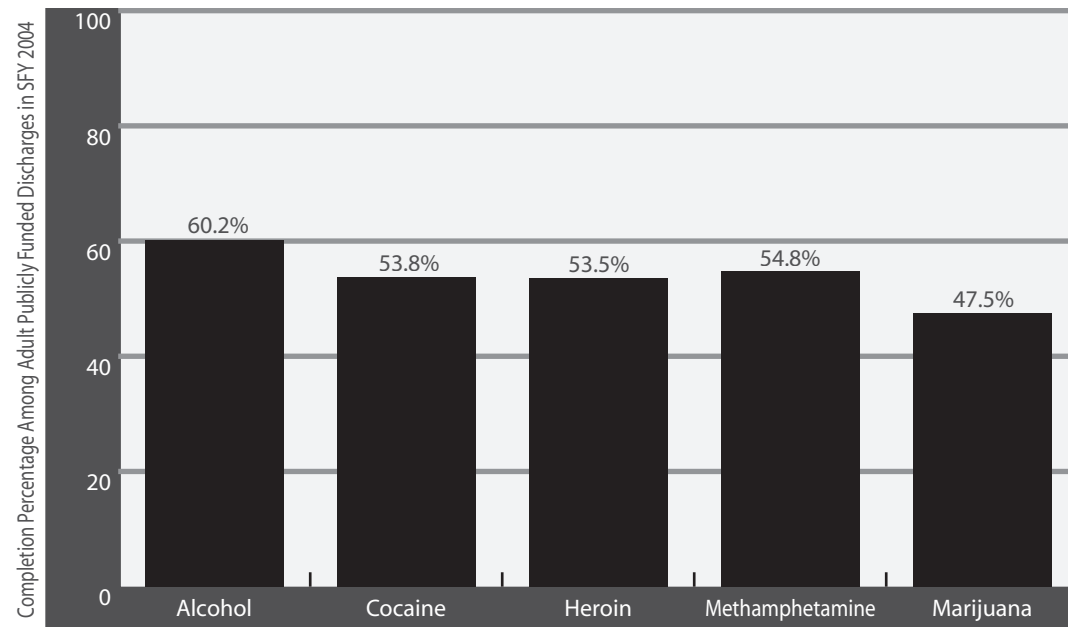
<i>Number of Individuals Admitted:</i>	4,533
<i>Median Age:</i>	28
<i>Gender:</i>	54% Male; 46% Female
<i>Employment Status:</i>	Employed (full- or part-time) – 12%; Unemployed – 8%
<i>Primary Drug:</i>	Alcohol – 49%; Stimulants (including Methamphetamine) - 19%; Marijuana - 13%
<i>Criminal Justice Involvement:</i>	63% arrested at least once in previous year
<i>% with Children in the Home:</i>	39%
<i>Housing Status:</i>	16% homeless*

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

Compared with all low-income adults receiving publicly funded treatment in Washington State in SFY 2004, those treated for methamphetamine addiction are substantially younger (median age 28, as opposed to 33 for low-income adults); more likely to be female (46% v. 40%); more likely have children in their home (39% v. 36%); and more likely to be homeless (16% v. 13%).

¹ Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2005. Data include unduplicated admissions to treatment, Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

Adult Patients Addicted to Methamphetamine Complete Publicly Funded Chemical Dependency Treatment at Rates Similar to Patients Addicted to Other Substances.

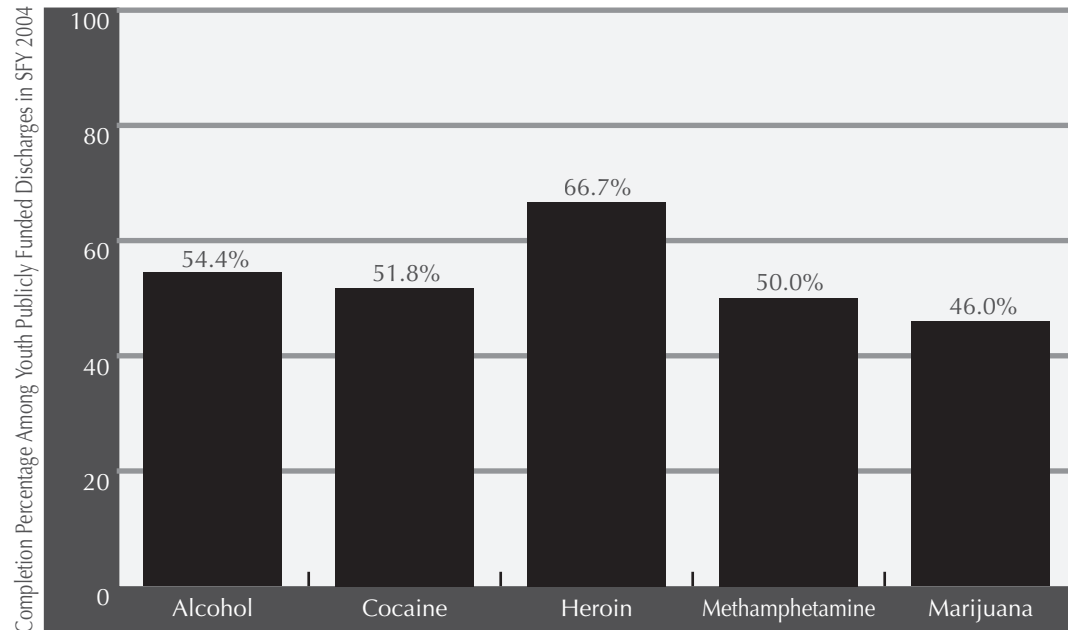


Source: DASA Treatment Analyzer, Washington State Division of Alcohol and Substance Abuse.

This graph indicates that adults receiving publicly funded treatment for methamphetamine addiction complete treatment at rates similar to (actually slightly higher than) adults addicted to other drugs. This holds true across treatment modalities – intensive inpatient, intensive outpatient, outpatient, recovery house, and long-term residential treatment.

It should be noted that the majority of individuals addicted to methamphetamine are polydrug users.

Youth Patients Addicted to Methamphetamine Complete Publicly Funded Chemical Dependency Treatment at Rates Similar to Patients Addicted to Other Substances.

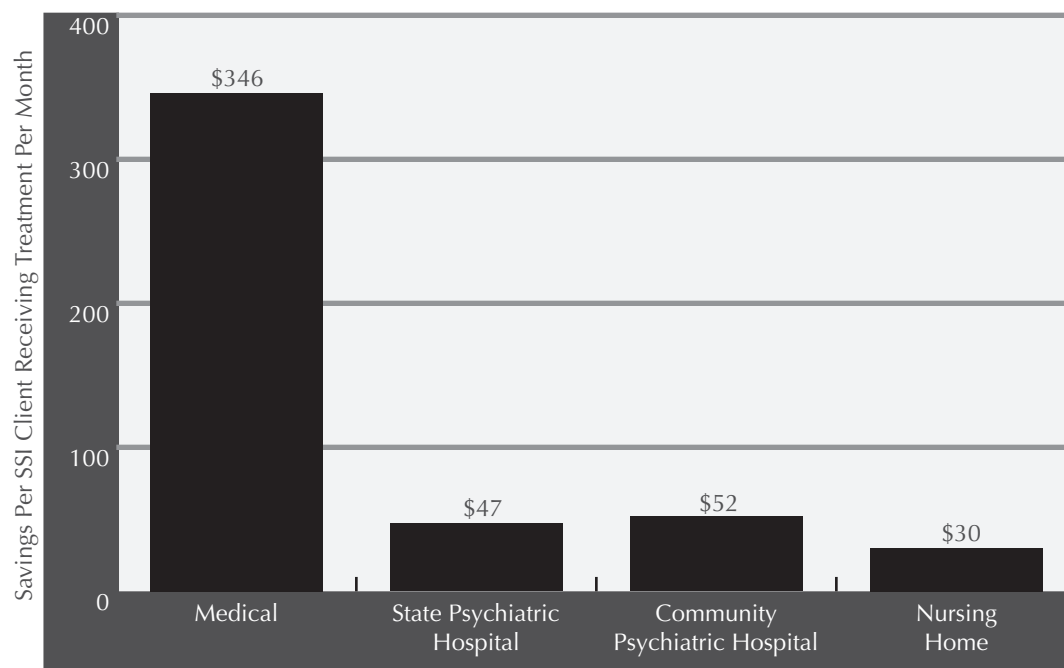


Source: DASA Treatment Analyzer, Washington State Division of Alcohol and Substance Abuse.

This graph indicates that youth ages 12-17 receiving publicly funded treatment for methamphetamine addiction complete treatment at rates similar to youth addicted to other drugs. This holds true across treatment modalities – intensive inpatient, intensive outpatient, outpatient, recovery house, and long-term residential treatment.

It should be noted that the majority of youth addicted to methamphetamine are polydrug users.

Treatment of Stimulant Addiction, Including Methamphetamine Addiction, Results in Substantial Savings in Health Care Costs Among Supplemental Security Income Recipients.

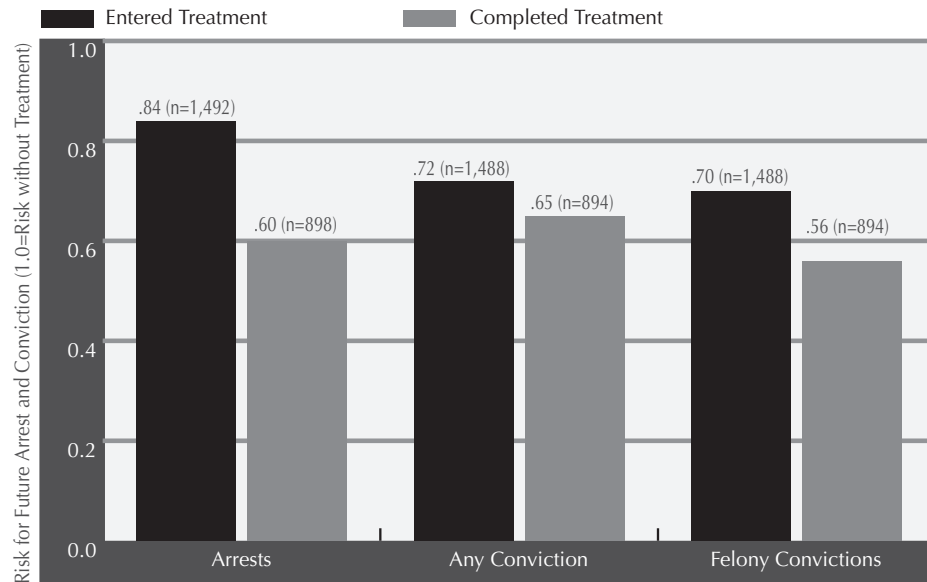


Source: Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

This graph indicates that there are substantial savings in health care costs for Washington State Supplemental Security Income (SSI) recipients who receive chemical dependency treatment for stimulant addiction (including methamphetamine addiction) compared with those who need such treatment but do not receive it. Even factoring in the cost of chemical dependency treatment (\$178 per month), the net savings in health care costs are \$296 per month or \$3,552 per year.

Providing treatment for stimulant (methamphetamine) addiction for SSI recipients in fact results in higher net cost savings (\$296/month) than treatment for addiction to other substances (\$267/month).

Treatment of Stimulant Addiction, Including Methamphetamine Addiction, Results in Reduced Risk for Arrest and Conviction Among Supplemental Security Income Recipients.*



Source: Estee, S. & Nordlund, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

This graph indicates that there are substantially reduced risks for arrest and conviction for Washington State Supplemental Security Income (SSI) recipients who receive chemical dependency treatment for stimulant addiction (including methamphetamine addiction) compared with those who need such treatment but do not receive it. The risk of arrest is 16% for those who enter treatment, and 40% lower for those who complete treatment. The risk of felony conviction is 30% lower for those who enter treatment, and 44% lower for those who complete treatment. Chemical dependency treatment for those addicted to methamphetamine is thus a good investment in safer communities and lower criminal justice costs.

* Risks reflect results of proportional hazard models in which the effects of covariates on re-arrest or conviction rates (e.g., age, gender, race/ethnicity) are controlled.

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Profile of Low-Income Adults Receiving Publicly Funded Chemical Dependency Treatment in Washington State

A profile of low-income adults admitted to publicly funded chemical dependency treatment in Washington State in SFY 2004 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	22,512
<i>Median Age:</i>	33
<i>Gender:</i>	60% Male; 40% Female
<i>Employment Status:</i>	Employed (full- or part-time) – 19%; Unemployed – 81%
<i>Primary Drug:</i>	Alcohol – 49%; Stimulants (including Methamphetamine) - 19%; Marijuana - 13%
<i>Criminal Justice Involvement:</i>	66% arrested at least once in previous year
<i>% with Children in the Home:</i>	36%
<i>Housing Status:</i>	13% homeless*

*Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2005. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

Publicly Funded Residential Chemical Dependency Treatment Results in Improved Outcomes in Employment and Medical Status, Lower Substance Use and Higher Rates of Abstinence, and Reduced Criminal Activity.



A 1999 study was undertaken by the University of Washington's Alcohol and Drug Abuse Institute to assess the quality and effectiveness of the Division of Alcohol and Substance Abuse's publicly funded adult residential chemical dependency treatment system. Some 577 low-income patients were assessed at admission to treatment, and six months following their discharge. The study found:

- Patients were much less likely to use alcohol and illegal drugs following treatment. Self-reported abstinence rates for alcohol use in the past 30 days increased by 87%, and by 109% for drug use. Of those who continued to report any drug use, the percentage of patients who used any illegal drugs for seven or more of the past 30 days declined 74%, from 50% at treatment admission to 13% at follow-up.
- The average number of self-reported days of illegal activity declined 85%. Average 30-day earnings from illegal activity declined 93%, from \$485 at admission to \$32 at follow-up.
- In the 30 days prior to admission to treatment, only 19.8% of patients worked ten or more days. In the 30 days prior to the six-month post-discharge follow-up, 40.7% worked ten or more days, representing a 94% increase. Average monthly income increased from \$159 at admission to \$568 at follow-up.
- The percentage of patients reporting no days of medical problems during the past 30 days increased by 25% at the post-discharge follow-up. The number of days with mental health distress was reduced by 48%.
- The number of days with significant family conflict during the past 30 days declined by 62% at the post-discharge follow-up.¹



Profile of Adults Receiving Temporary Assistance for Needy Families Served By Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of patients receiving Temporary Assistance for Needy Families (TANF) admitted to publicly funded treatment in Washington State in SFY 2004 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	3,741
<i>Median Age:</i>	29
<i>Gender:</i>	27% Male; 73% Female
<i>Employment Status:</i>	Employed (full- or part-time) – 11%; Unemployed – 89%
<i>Primary Drug:</i>	Alcohol – 35%; Stimulants (including Methamphetamine) - 26%; Marijuana 21%
<i>Criminal Justice Involvement:</i>	55% arrested at least once in previous year
<i>% with Children in the Home:</i>	75%
<i>Housing Status:</i>	6% homeless*

A study of adults receiving TANF admitted to publicly funded chemical dependency treatment in Washington State, July 1998 – June 1999, indicated:

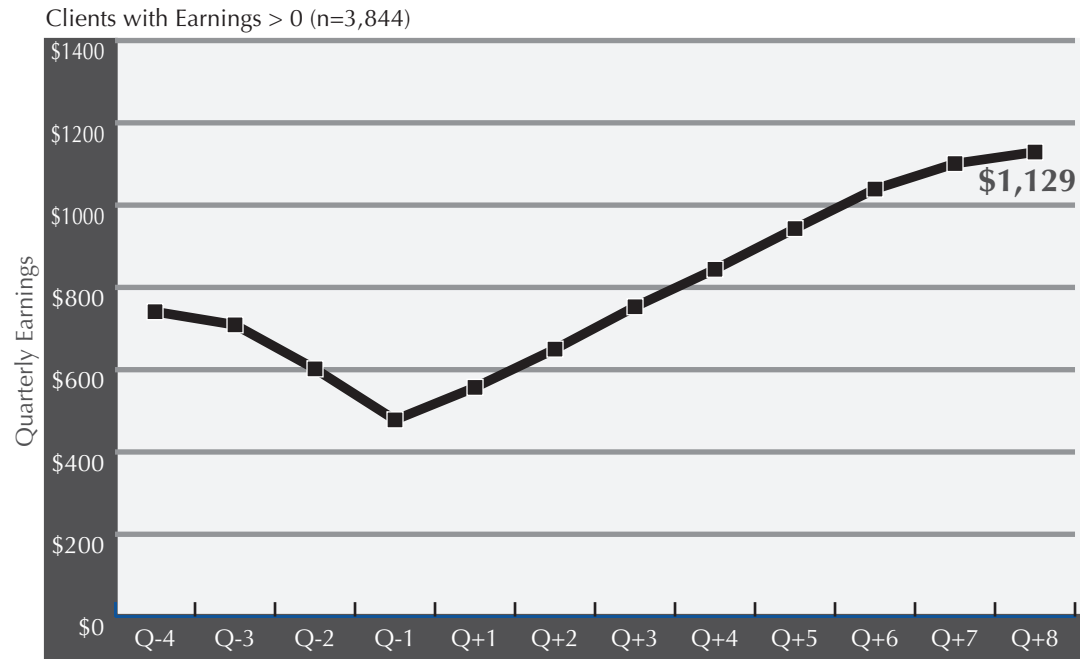
- One out of three women did not have a high school diploma or GED;
- Three out of four women reported they had been victims of domestic violence at some point in their lives;
- 21% reported receiving mental health treatment in the previous year;
- One out of three women reported using injection drugs at some point in their lives.²

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

¹ Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2005. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

² Rodriguez, F. *Key Characteristics of TANF Adults Admitted to Publicly Funded Treatment in Washington State, July 1998 – June 1999*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2000.

AFDC Clients Who are Employed Show Major Increases in Earnings Following Chemical Dependency Treatment.



Source: Wickizer, T., et al. "Employment Outcomes Among AFDC Recipients Treated for Substance Abuse in Washington State," *The Millbank Quarterly* 78(4), 2000.

This graph indicates that chemically dependent clients receiving AFDC ("Aid to Families with Dependent Children") support showed marked declines in employment income in the year prior to receiving chemical dependency treatment, and more than doubled their average employment income in the two years following treatment. AFDC in Washington State has now been replaced by TANF ("Temporary Assistance for Needy Families"). This 2000 study confirms the results of earlier studies indicating that chemical dependency treatment assists low-income patients in moving toward self-sufficiency.

Outcomes: The Benefits of Prevention & Treatment

**TREATMENT
OUTCOMES
FOR:**

Adolescents

Pregnant Women

ADATSA Patients

Supplemental
Security Income
Recipients

Co-Occurring
Disorders

Individuals
Addicted to
Methamphetamine

Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

Patient
Satisfaction



Profile of Patients Receiving Publicly Funded Opiate Substitution Treatment in Washington State

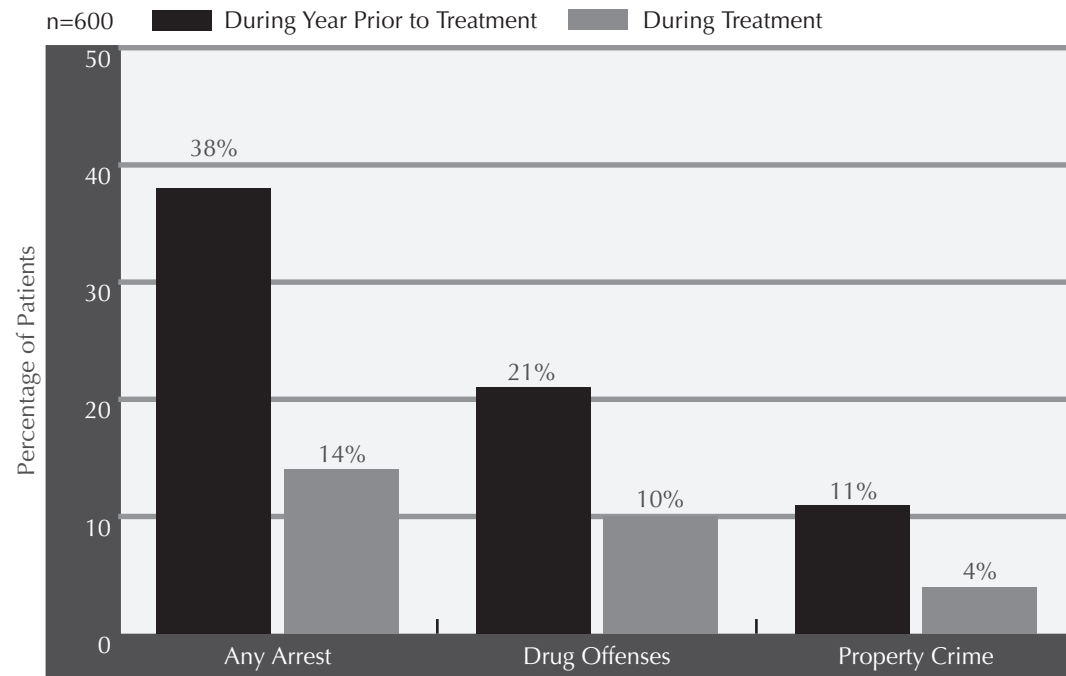
A profile of patients admitted to publicly funded opiate substitution treatment in Washington State in SFY 2004 reveals the following characteristics at time of admission:¹

<i>Number of Individuals Admitted:</i>	1,210
<i>Median Age:</i>	41
<i>Gender:</i>	47% Male; 53% Female
<i>Employment Status:</i>	Employed (full- or part-time or temporary) – 6%; Unemployed – 94%
<i>Primary Drug:</i>	Heroin – 85%; Other – 15%
<i>Criminal Justice Involvement:</i>	28% arrested at least once in previous year
<i>% with Children in the Home:</i>	29%
<i>Housing Status:</i>	16% homeless*

*Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.

¹ Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, June 2005. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

Criminal Arrests Among Publicly Funded Opiate Substitution Patients Decreased During Treatment When Compared to the Year Prior to Treatment.



Source: Baxter, B., and Albert, D., *Report to the Legislature: Determining the Value of Opiate Substitution Treatment*, 2002.

This graph indicates that patients receiving publicly funded opiate substitution treatment are less likely to be arrested for a crime during treatment than in the year prior to treatment.

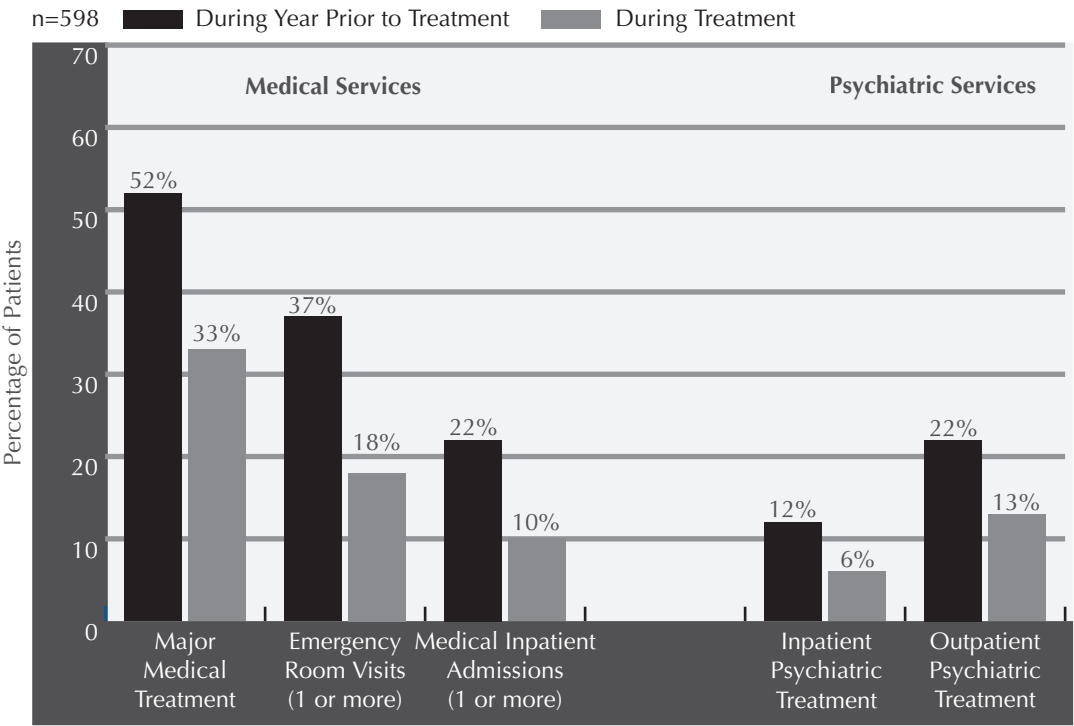
It is estimated that in 2000, almost 31,000 Washington State adults were in need of treatment for heroin addiction.¹ Sixteen opiate substitution clinics currently provide treatment through administration of methadone and delivery of counseling services. In addition, patients receive education, random urine drug screening to monitor drug use, and are subject to stringent rules regarding compliance. In SFY 2003, 4,923 patients were enrolled in opiate substitution programs in Washington State, 2,664 (54.1%) of whom were publicly funded.²

¹ Albert, D., *Determining the Value of Opiate Substitution Treatment*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, January 2004.

² Data do not include patients enrolled in Veterans Administration programs.



Health Care Utilization Among Publicly Funded Opiate Substitution Patients Decreased During Treatment When Compared to the Year Prior to Treatment.



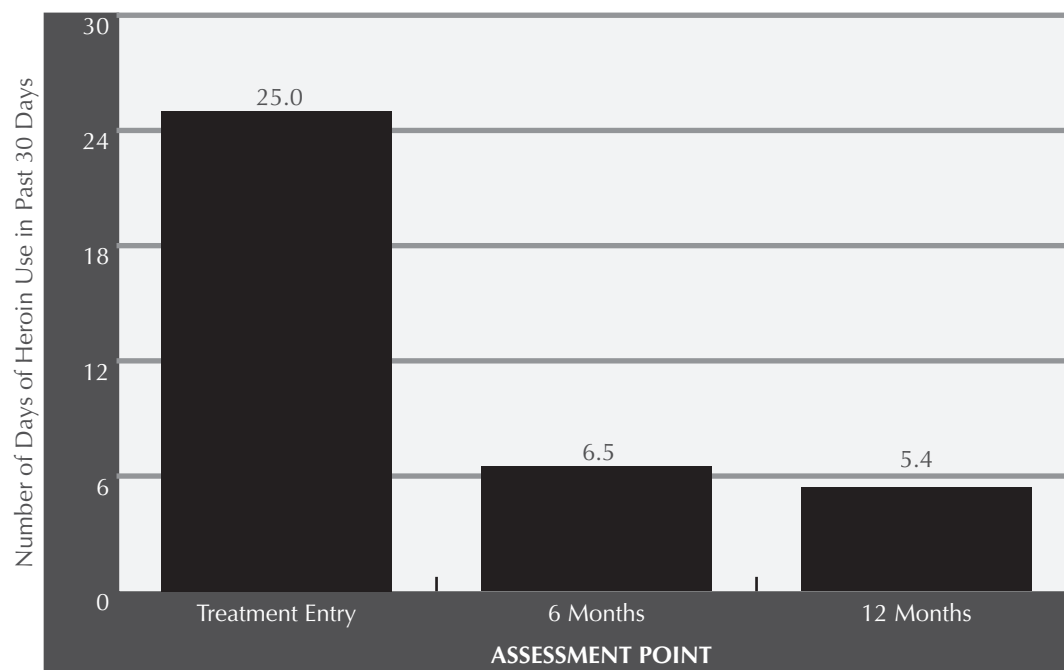
Source: Baxter, B., and Albert, D., *Report to the Legislature: Determining the Value of Opiate Substitution Treatment* - 2002.

Opiate substitution treatment has been scientifically shown to work. The federal Office of National Drug Control Policy called methadone therapy, “one of the longest-established, most thoroughly evaluated forms of drug treatment.”¹ A Consensus Panel convened by the National Institutes of Health in 1997 concluded, “Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity.”²

This graph indicates that patients receiving publicly funded opiate substitution treatment use fewer health care and psychiatric services during treatment than in the year prior to treatment. This results in significant cost savings throughout the health care system.

¹ Office of National Drug Control Policy, *The National Drug Control Strategy: 2000 Annual Report*. Washington, DC: Office of the White House, 2000.
² National Institutes of Health, *Effective Medical Treatment of Heroin Addiction: NIH Consensus Statement 1997*. November 17-19, 1997 15(6).

Patients Receiving Opiate Substitution Treatment Show Significant Decreases in Heroin Use.



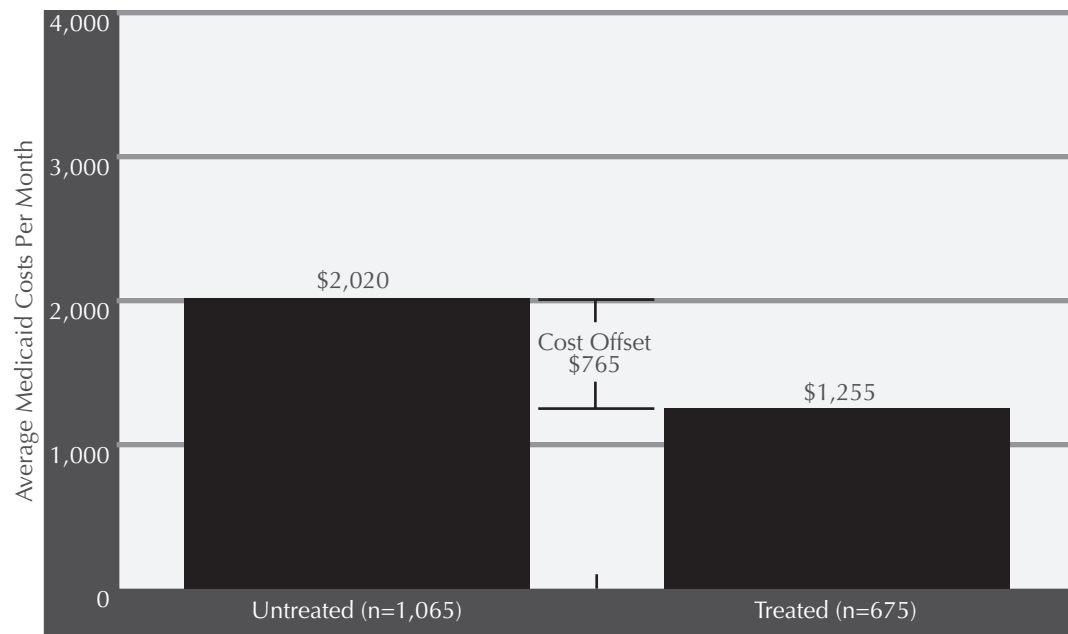
Source: Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

A 2003 study of 135 patients admitted to publicly funded opiate substitution treatment in Washington State in 2000 demonstrated significant reductions in the average number of days they engaged in heroin use. At entry into treatment, patients reported an average of 25 days of heroin use in the past 30 days. At six months, this was reduced to 6.5 days, and at 12 months, to 5.4 days, representing a 78% decline. More than four out of five patients reported a reduction in the number of days using heroin at the six- and 12-month follow-ups.¹

¹ Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.



Providing Methadone Treatment for Opiate-Addicted Supplemental Security Income Recipients Reduces Health Care Costs.



Source: Nordlund, D., et al., "Methadone Treatment for Opiate Addiction Lowers Health Care Costs and Reduces Arrests and Convictions." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

Medicaid-paid medical, mental health, and long-term care costs are significantly lower for Supplemental Security Income (SSI) recipients addicted to opiates who receive methadone treatment, compared to those who remain untreated. Even after the monthly cost of treatment (\$219/month) is included, the net cost savings per patient is \$765 per month, or a potential savings of \$9,180 per treated SSI recipient per year.

Savings are substantial (\$725/month) even for SSI recipients who are opiate-addicted even if they leave treatment with the first 90 days. However, for those who remain in treatment for at least one year, cost offsets rise to \$899 per month per recipient.

¹ Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

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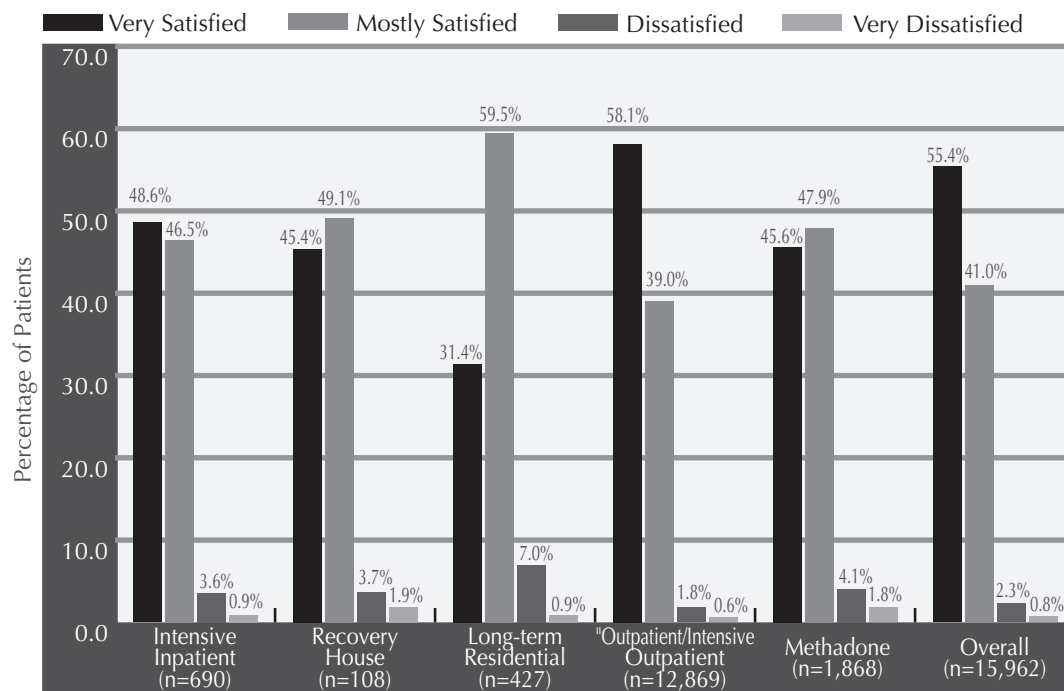
Low-Income
Patients

Patients Receiving
Opiate Substitution
Treatment

**Patient
Satisfaction**

In 2005, 96% of Adult Patients Receiving Chemical Dependency Treatment Services in Community-Based Programs Reported Overall Satisfaction with the Services They Received.

“In an overall, general sense, how satisfied are you with the services you have received?”



Source: Rodriguez, F., *Patients Speak Out 2005: Fifth Annual Statewide Patient Satisfaction Survey*. Olympia, WA: Division of Alcohol and Substance Abuse, 2005.

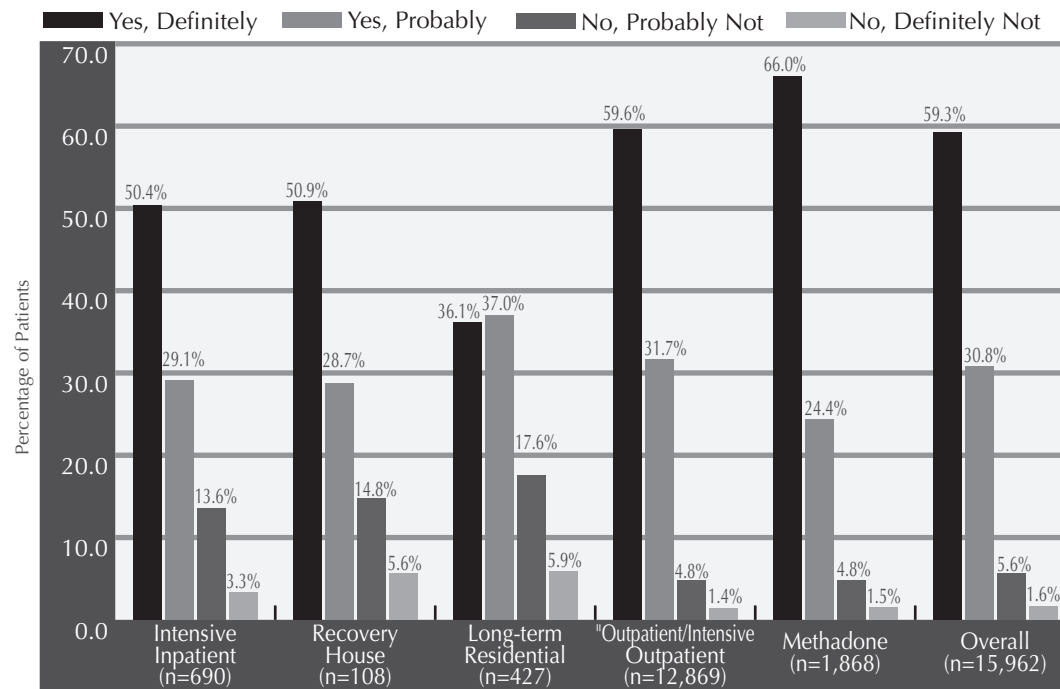
In March 2005, DASA conducted its fifth statewide patient satisfaction survey. It was administered at 444 community-based and correctional treatment centers to 18,748 patients, or 76% of those receiving treatment in the participating agencies during the week of the survey.

Overall, 95% of adult patients treated in community-based agencies reported they were satisfied with the comfort and appearance of their treatment facilities; 98% said they were treated with respect by staff; 92% rated group sessions as helpful; and 87% reported they found individual counseling to be helpful. Reports of responses to the survey are sent to each of the respective treatment agencies for use in quality improvement activities.

In 2005, 90% of Adult Patients Receiving Chemical Dependency Treatment in Community-Based Programs Reported They Would Return to the Same Program If They Needed Help Again.



“If you were to seek help again, would you come back to this program?”



Source: Rodriguez, F., *Patients Speak Out 2005: Fifth Annual Statewide Patient Satisfaction Survey*. Olympia, WA: Division of Alcohol and Substance Abuse, 2005.

In March 2005, DASA conducted its fifth statewide patient satisfaction survey. It was administered at 444 community-based and correctional treatment centers to 18,748 patients, or 76% of those receiving treatment in the participating agencies during the week of the survey.

Many patients receiving chemical dependency treatment require other services as well. Treatment agencies play a key role in assisting patients in identifying and accessing these services. Of those reporting a need for them: 75% of adult patients said their treatment program was helpful in connecting them to legal services; 78% to medical services; 77% to family services; 74% to mental health services; 66% to educational or vocational services; and 56% to employment services.

Treatment Completion





Treatment Completion Improves Patient Outcomes

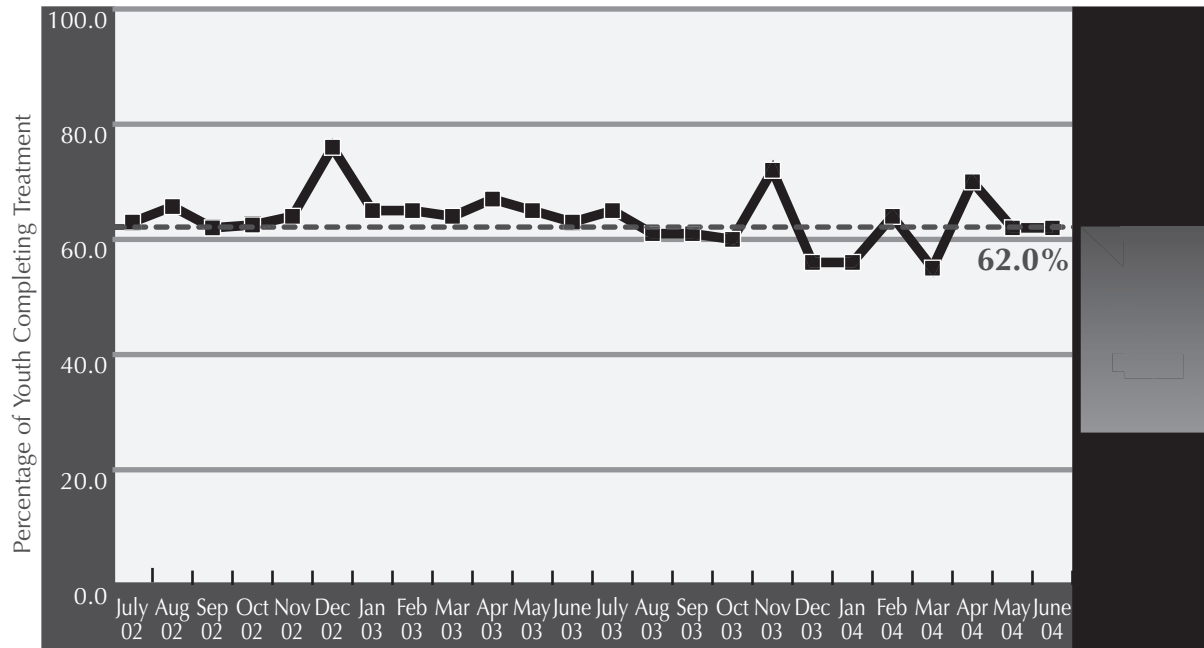
As part of the Department of Social and Health Services' pledge to ensure better outcomes for the state residents it serves, the Division of Alcohol and Substance Abuse (DASA) has committed itself to improving completion and retention rates for publicly funded patients receiving chemical dependency treatment.

Multiple studies, conducted in Washington State and elsewhere, demonstrate that outcomes following from treatment participation are significantly enhanced when patients complete treatment. For example, relative to patients who did not complete treatment, completers have been found to:

- Have higher employment and wages following discharge from treatment;
- Be arrested and convicted less frequently after discharge;
- Have significantly fewer inpatient medical hospital admissions and are less likely to require emergency medical services after discharge;
- If pregnant, are more likely to have full-term deliveries, babies with higher birth weights, and fewer fetal or infant deaths; and
- Produce higher cost savings to public systems following discharge.

In the pages that follow, results from studies that illustrate the above points are featured. All studies have been conducted in Washington State with publicly funded clients. Taken together, they suggest that improving treatment completion rates is one of the most powerful ways to maximize benefits from the limited public resources available to fund chemical dependency treatment. DASA is now working with researchers, counties, tribes, and both residential and outpatient treatment providers to set targets and incorporate best practices to improve completion rates throughout the state.

Residential Treatment Completion Rates for Youth are at the July 2004 Target of 62%.



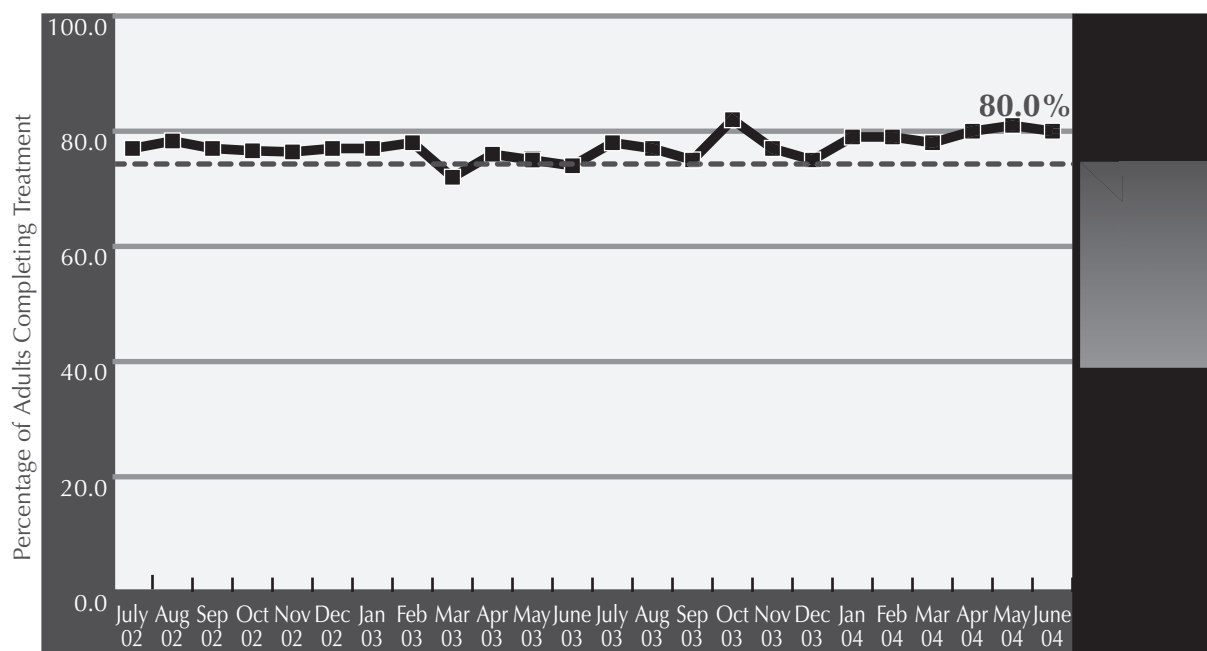
Source: Program Review, Division of Alcohol and Substance Abuse, June 2004.

The Division of Alcohol and Substance Abuse has set a goal of increasing the percentage of low-income and indigent youth who complete publicly funded chemical dependency treatment. Research has demonstrated that treatment completion is closely linked to better outcomes for both adults and youth. Cumulative data from July 2003-June 2004 indicate that 61.8% of low-income and indigent youth completed treatment.

Over the past year, the clinical severity of youth being treated in residential treatment programs has increased. A larger percentage of patients are being admitted to higher and more secure levels of care, and for longer length-of-stay.



Residential Treatment Completion Rates for Adults Now Consistently Exceed the July 2004 Target of 76%.



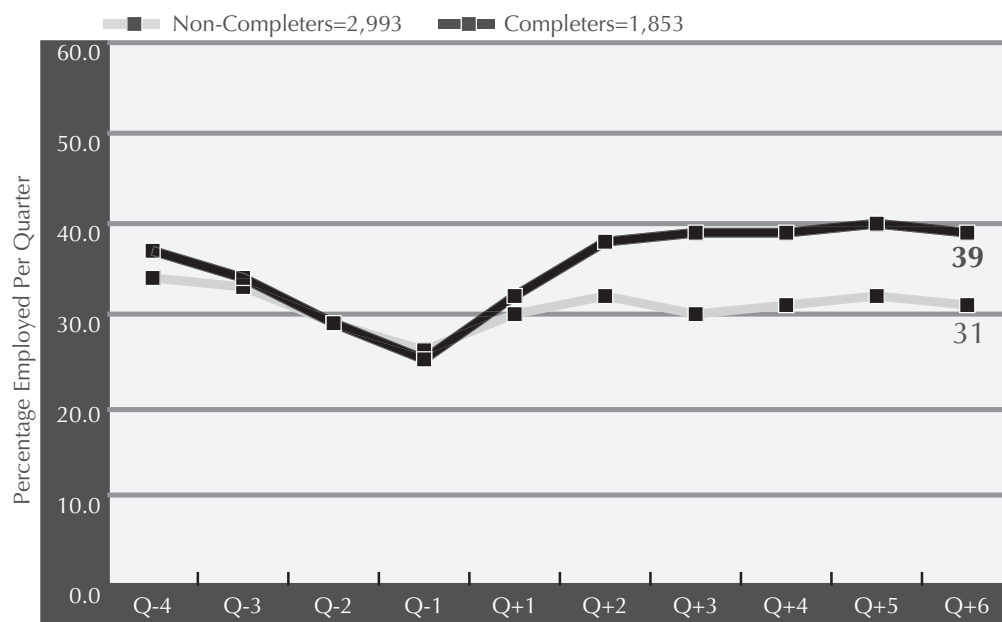
Source: Program Review, Division of Alcohol and Substance Abuse, June 2004.

The Division of Alcohol and Substance Abuse has set a goal of increasing the percentage of low-income adults who complete publicly funded chemical dependency treatment. Research has demonstrated that treatment completion is closely linked to better outcomes for both adults and youth. Cumulative data from July 2003-June 2004 indicate that 78.4% of low-income adults completed treatment.

Treatment Completers are More Likely to Become Employed After Treatment.



Percentage of ADATSA Patients Employed During the Four Quarters Before Admissions and Six Quarters After Discharge from Chemical Dependency Treatment



Source: Luchansky, B. and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* 2002.

In a recent study of ADATSA patients¹, employment trends among treatment completers and non-completers were tracked. Prior to treatment, both completers and non-completers experienced declining rates of employment (see Quarters -4 through -1 on graph above). After treatment, employment rates rose for both groups, but the rise was significantly greater for completers: during the sixth quarter after treatment began, 39% of the completers were employed compared to 31% of the non-completers, representing a difference of 25.8%.²

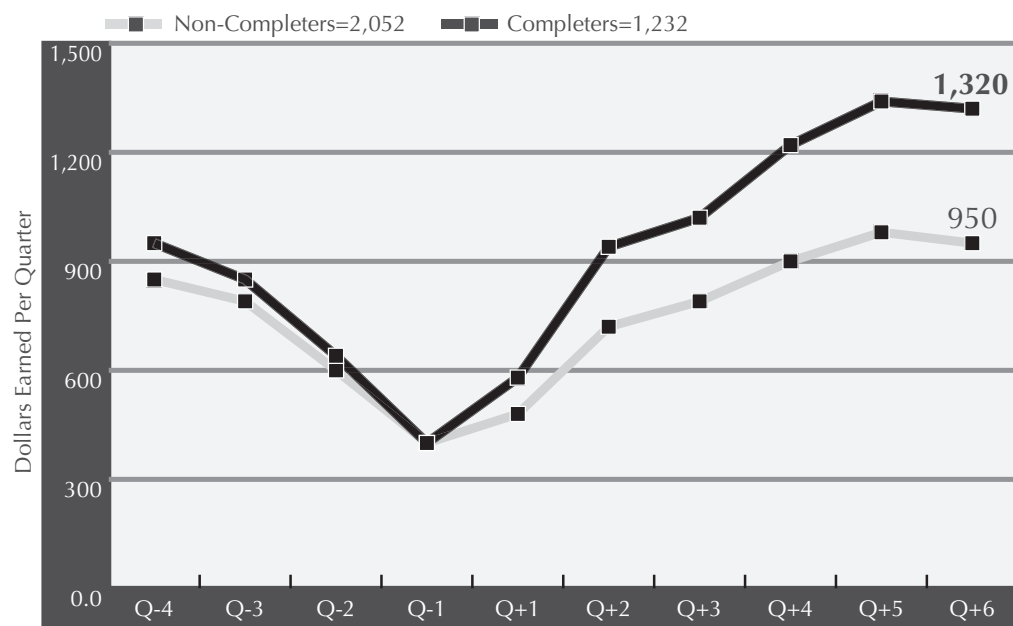
¹ ADATSA is a state-funded program that provides a continuum of care to persons who are indigent and deemed unemployable as a result of alcoholism and/or other drug addiction. ADATSA stands for the legislation that funds this program, the Alcoholism and Drug Addiction Treatment and Support Act.

² Luchansky, B. and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.



Treatment Completers Show Pronounced Post-Treatment Wage Increases.

Quarterly Wages for ADATSA Patients During Four Quarters Before Admission and Six Quarters After Discharge from Chemical Dependency Treatment



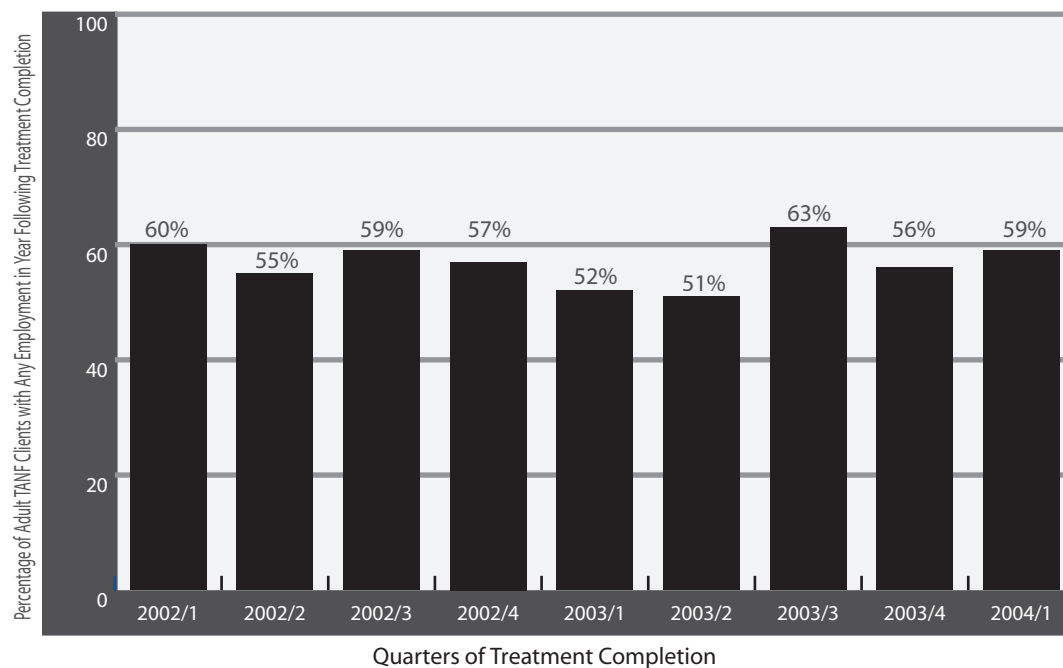
Source: Luchansky, B. and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* 2002.

In a recent study of ADATSA patients¹, among those who were employed, it was found that pre-treatment wages for those who completed and those who did not complete chemical dependency treatment were similar. For both groups, wages began to decline four quarters before beginning treatment and continued to decline until treatment began. After treatment, wages rose for both groups. However, the increase in wages for treatment completers was more pronounced than for non-completers. During the sixth quarter after treatment began (see Q+6 on chart), completers earned \$1,316 on average, while non-completers earned \$941, a difference of \$375, representing a 39.8% difference.²

¹ ADATSA is a state-funded program that provides a continuum of care to persons who are indigent and deemed unemployable as a result of alcoholism and/or other drug addiction. ADATSA stands for the legislation that funds this program, the Alcoholism and Drug Addiction Treatment and Support Act.

² Luchansky, B., and He, L., *Employment Outcomes of Chemical Dependency Treatment: Analyses from Washington State. An Interim Report.* Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2002.

About 60% of Adult Clients Enrolled in the Temporary Assistance for Needy Families (TANF) Program and Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.

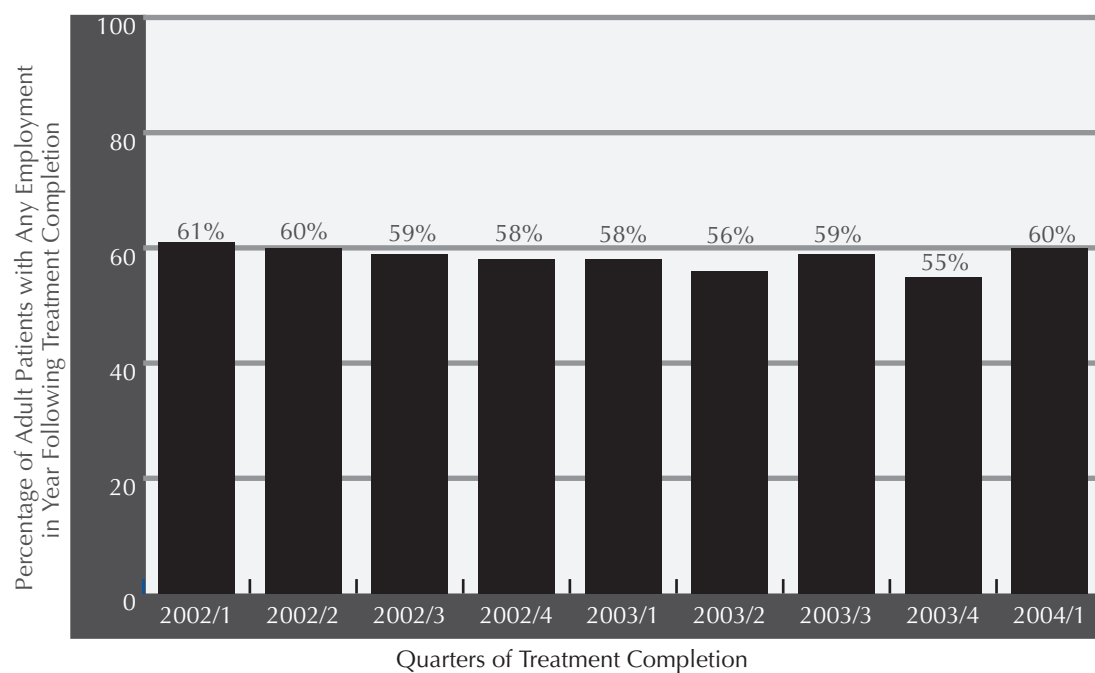


Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2005.

This graph indicates that of clients enrolled in the Temporary Assistance for Needy Families (TANF) program who completed chemical dependency treatment in the first quarter of SFY 2004, and did not require further treatment, 59% became employed in the following 12 months. Some 40% of those employed worked more than 20 hours a week; 39% of those employed earned wages above the Federal Poverty Level. For TANF clients with substance abuse problems, chemical dependency treatment helps move them toward economic self-sufficiency.



Some 60% of Adult Patients Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.



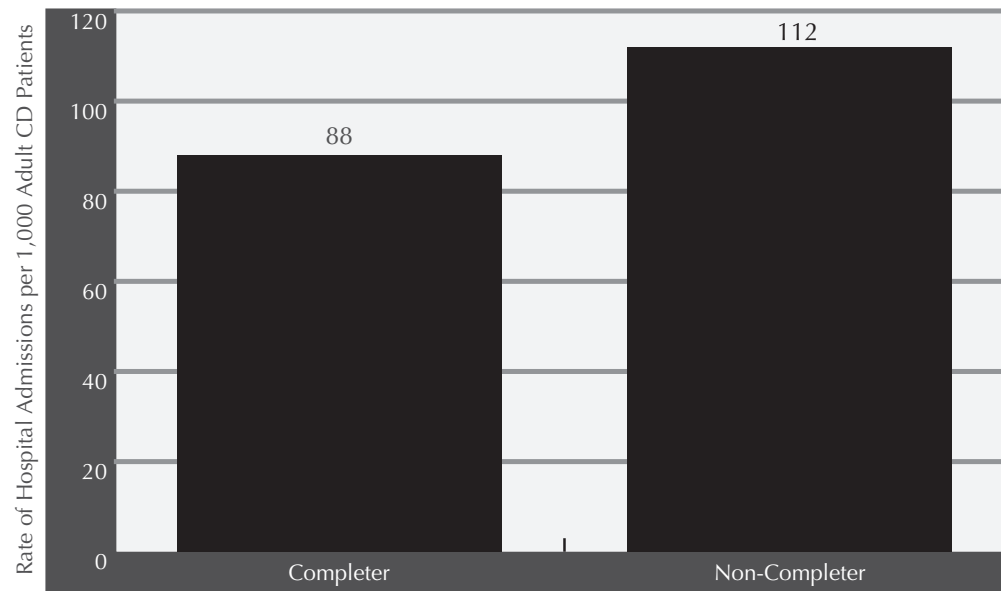
Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2005.

This graph indicates that three out of five adult low-income patients who completed chemical dependency treatment in the first quarter of SFY 2004, and did not require further treatment, became employed in the following 12 months. Average monthly wages were approximately \$910. More than half of those employed (54%) worked more than 20 hours a week; 57% of those employed earned wages above the Federal Poverty Level. Chemical dependency treatment clearly helps move individuals with substance abuse problems toward economic self-sufficiency.

Treatment Completers Had Lower Hospital Admission Rates Following Chemical Dependency Treatment.



Adjusted Rates of Hospital Admissions per 1,000 Patients in the Year Following a Treatment Episode



Source: Luchansky, B., et al., *Substance Abuse Treatment and Hospital Admissions: Analyses from Washington State, 2002*.

A study of almost 10,000 adult patients who received publicly funded chemical dependency (CD) treatment in 1995 showed that patients who completed CD treatment were 21% less likely to be admitted to a hospital in the year following discharge compared to patients who did not complete treatment.¹



Completion of Treatment and Treatment Retention are Associated with Reduced Risk of Felony Arrests Among Adults, and Convictions Among Youth.

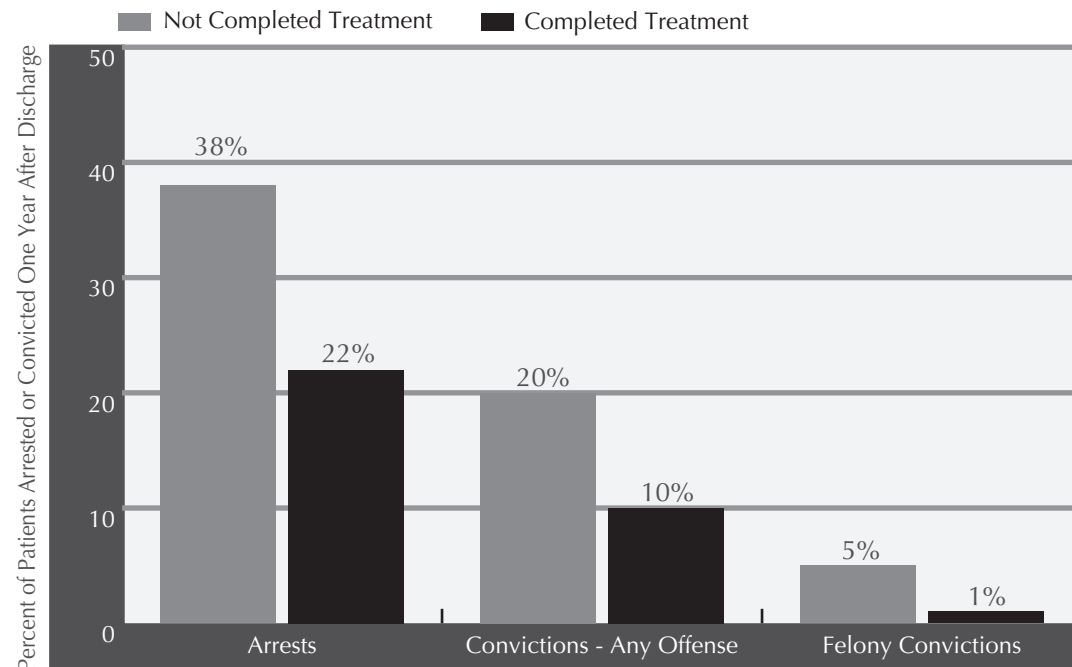
Research, both in Washington State and elsewhere, has consistently shown that admission to chemical dependency treatment is associated with lower crime rates, fewer arrests, and lower criminal justice costs. More recent studies highlight the benefits of both treatment completion and longer retention in treatment:

- A 2002 study of over 10,000 adult patients who received publicly funded chemical dependency treatment in 1995 demonstrated that the probability for a felony offense was 21% lower in the following year for patients completing treatment when compared to patients who did not complete treatment. For patients whose treatment episode was greater than 90 days, the probability of a felony arrest was 32% less than for patients with shorter treatment episodes.¹
- A 2003 study of almost 6,000 youth who participated in substance abuse treatment between 1997 and 1998 indicated that patients completing treatment had a 29% reduction in the risk of a subsequent felony conviction, and a 17% reduction in risk of any conviction in the year following discharge, compared to non-completers.²

¹ Luchansky, B., et al., *Substance Abuse Treatment and Arrests: Analyses from Washington State (Fact Sheet 4.42)*. Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, 2002.

² Luchanski, B., et al., *Treatment Readmissions and Criminal Recidivism in Youth Following Participation in Chemical Dependency Treatment*. Manuscript being prepared for publication, 2003.

Treatment Completion was Associated with Reductions in Arrests and Convictions Among Supplemental Security Income Recipients.*



Source: Estee, S., & Nordland, D., *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*.

A study completed in 2003 indicates that Supplemental Security Income (SSI) recipients who completed chemical dependency treatment had lower rates of arrest, convictions for any type of offense, and felony convictions one year after discharge than those who did not complete treatment. Rates of arrest were 42% lower, rates of convictions 50% lower, and rates of felony conviction 80% lower.¹

* Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for Social Security Title II benefits. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.



Supplement Security Income Recipients Who Completed Chemical Dependency Treatment Had Lower Medical, Psychiatric, and Nursing Home-Related Costs than Those Who Did Not Complete Treatment.*

Source of Costs ¹	Treatment Completers	Treatment Non-Completers
Medical Costs	-\$380	-\$292
Mental Health Costs		
<i>State Hospital Costs</i>	-\$56	-\$46
<i>Community Psychiatric Hospital Costs</i>	-\$33	-\$11
Nursing Home Costs	-\$65	-\$53

Source: Estee, S., & Nordland, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*.

In a study of over 7,000 Supplemental Security Income (SSI) recipients who entered chemical dependency treatment, those who completed treatment had lower monthly medical, psychiatric, and nursing home costs, and hence higher monthly cost offsets than those who did not. Medical care expenses for SSI recipients who completed treatment were \$380 lower than the cost of medical care for those who needed chemical dependency treatment but remained untreated. SSI recipients who did not complete treatment also had lower costs, but by only \$292, or 22.4% less.²

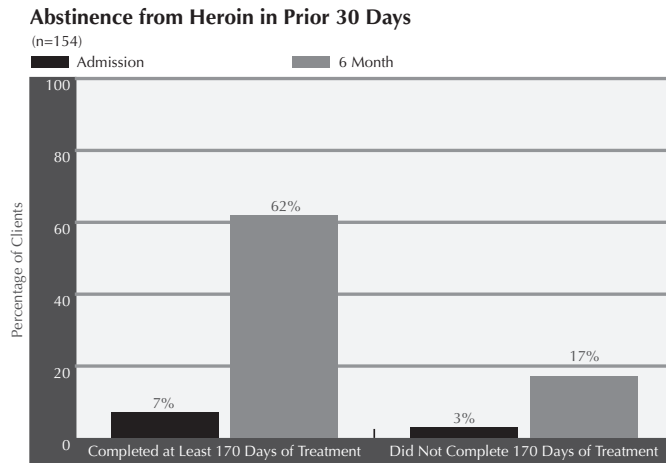
* Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for Social Security Title II benefits. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.

¹ Costs represent the adjusted average monthly per person difference in costs for SSI recipients receiving chemical dependency treatment compared to costs for those who needed treatment but did not get it.

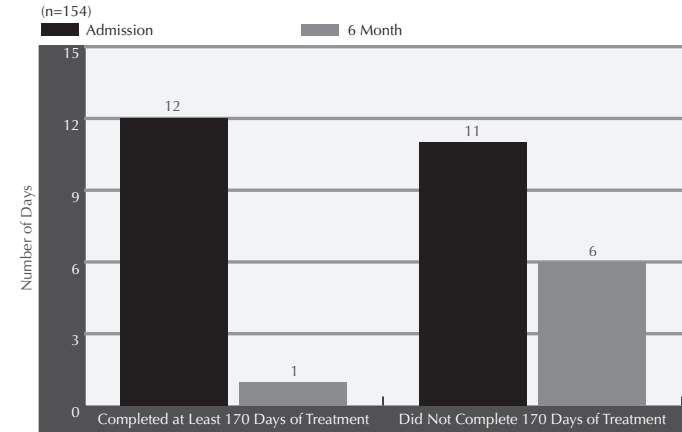
² Estee, S., & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project – 2002 Progress Report*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

Remaining in Treatment Results in Improved Outcomes Among Patients Receiving Methadone Treatment.

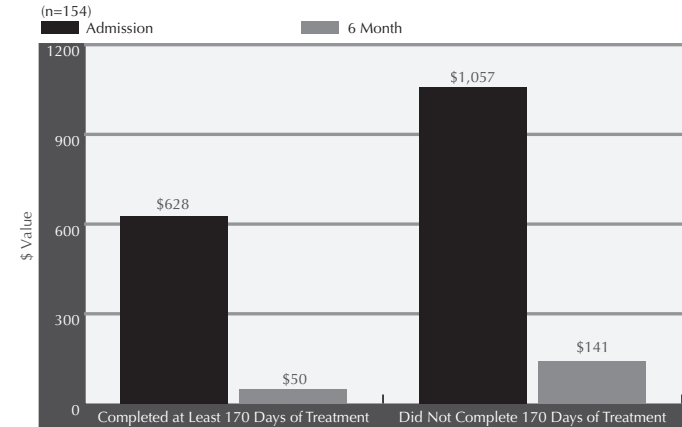
A 2001 study of 154 patients admitted to methadone treatment found that at a six-month follow-up, those who completed at least 170 days of treatment reported substantially higher rates of abstinence from heroin use, fewer days of illegal activity, and substantial decreases in money obtained through illegal activity.



of Days Engaging in Illegal Activity in Prior 30 Days
(n=154)

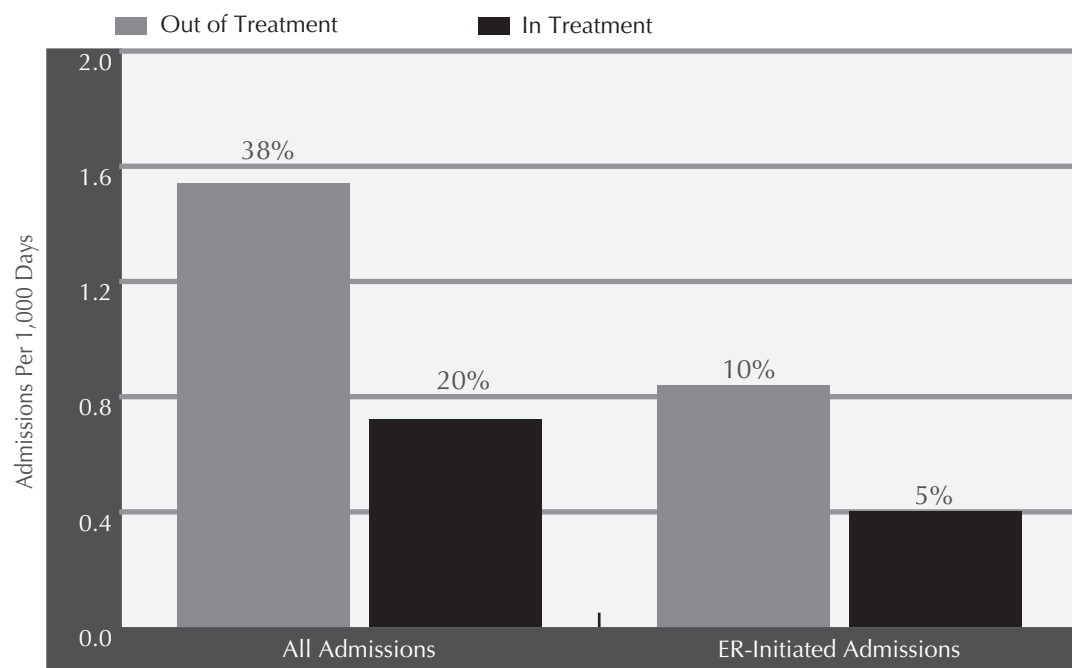


Average \$ from Illegal Sources in Prior 30 Days
(n=154)





Opiate Substitution Treatment Patients are Less Likely to Be Admitted to Hospitals While in Treatment.



Source: Luchansky, B., et al., *Substance Abuse Treatment and Inpatient Hospital Admissions for Clients in Opiate Dependency Treatment: Longitudinal Analyses from Washington State*. Manuscript being prepared for publication, 2003.

A recent study conducted for the Division of Alcohol and Substance Abuse reported that publicly funded opiate substitution treatment patients were significantly more likely to be admitted to a hospital while they were out of treatment as compared to when they were in treatment. Patients in treatment were 33% less likely to experience a hospital admission than those who left treatment. Most of the hospital admissions came through either the emergency room (56%) or through an urgent care facility (21%). Such acute care services are among the most costly. Medicaid or Medicare paid for 82% of these hospital admissions; only 15% were paid by a private payer.¹ Thus, retention in opiate substitution treatment results in better health for patients, and lower costs to the public.

¹ Luchansky, B., et al., *Substance Abuse Treatment and Inpatient Hospital Admissions for Clients in Opiate Dependency Treatment: Longitudinal Analyses from Washington State*. Manuscript being prepared for publication. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2003.

Longer Retention in Opiate Substitution Treatment is Associated with Higher Methadone Dose.

	Average Peak Methadone	Average Number of Days in Treatment
Opiate Substitution Treatment Program #1	109 mg/day	284.2
Opiate Substitution Treatment Program #2	83.1 mg/day	193.5

Source: Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

Longer retention in opiate substitution treatment is associated with better outcomes: less crime and involvement with the criminal justice system, fewer medical hospitalizations and emergency room visits, lower medical costs, fewer psychiatric hospitalizations, and less reliance on public assistance.

A 2003 study of 135 individuals admitted to two Washington State opiate substitution treatment programs found a close association between average peak methadone dose and average number of days in treatment. Patients in the programs where average peak dose was 109 mg/day remained in treatment an average of 90.7 days longer than those in the program where average peak dose was 83.1 mg/day, a difference of 46.8%. In addition, it was found that patients whose peak methadone dose was less than 75 mg/day were significantly more likely to leave treatment prior to 170 days. The mean peak methadone dose for patients who left treatment prior to 170 days was 78.0 mg/day, compared with a peak dose of 104.6 mg/day for those who remained in treatment at least 170 days.¹

¹ Source: Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

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Brief Interventions in Emergency Department and Health Care Settings

Traumatic injury inflicts enormous medical and psychosocial harm on its victims. The greatest underlying cause of injury is the misuse of alcohol and drugs.¹ By intervening in the substance abuse of individuals who frequent emergency departments, alcohol/drug abuse can be reduced, as can injuries requiring emergency department admissions.

Substantial numbers of individuals who visit hospital emergency departments (EDs) present with a diagnosis or injury caused by substance use or abuse disorders. A 2004 study found that nationally between 1992 and 2000, there was an average of 7.6 million ED visits per year for alcohol alone, or 7.9% of all such visits. This is approximately three times higher than previously estimated, based on physician documentation or patient disclosure of alcohol involvement.² It has been estimated that 20-50% of adult primary care patients may abuse alcohol or drugs and go undetected by their provider.

A wide range of effective treatments has been developed for mild, moderate, and severe drug and alcohol problems. Prior studies have shown that interventions, when delivered to injured patients in hospital EDs and on the inpatient units of hospitals, can reduce alcohol and drug consumption, prevent re-injury, and help patients with more severe problems access intensive, community-based chemical dependency treatment. These services demonstrate that counseling and referral helps reduce adverse health outcomes, reduces cost for medical care, reduces future emergency room use, reduces criminal justice involvement, and improves employment outcomes.

A study conducted at the trauma center at Harborview Hospital in Seattle found that of 2,524 patients screened, 1,153 or 46% tested positive for alcohol abuse. Patients were then randomized either to a control group, or to receive a brief onsite intervention related to the patients' drinking,

including information about the risks of alcohol abuse and the availability of treatment resources. At the 12-month followup, the intervention group had decreased alcohol consumption by an average of 21.8 drinks per week. At the three-year followup, there had been a 47% reduction in injuries requiring either emergency department or trauma center admission, and a 48% reduction in injuries requiring hospital admission.³

Besides reducing injuries and future ED admissions, early identification of alcohol and drug problems and brief intervention is, in some instances, an effective and cost-saving alternative to more intensive chemical dependency treatment. Early identification of alcohol and drug problems holds out the hope of preventing the progression of chronic substance abuse and dependence.

Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT)

In 2003, the Department of Social and Health Services, Division of Alcohol and Substance Abuse (DASA) received a \$16.1 million 5-year grant from the federal Substance Abuse and Mental Health Services (SAMHSA), Center For Substance Abuse Treatment (CSAT) to implement the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) program.

The goals of WASBIRT are to:

- Provide substance abuse screening in six EDs, thereby identifying a large number of patients who have substance abuse problems of all severity levels;
- Deliver brief interventions in EDs to patients admitted to the hospital who are not dependent, but whose misuse places them at increased risk for future re-injury or hospitalization;

- Provide brief treatment (5-12 sessions) on an outpatient basis to some patients who need and want more intensive, brief preventive treatment;
- Increase the number of referrals made to community-based chemical dependency treatment for patients dependent on alcohol and other drugs;
- Reduce subsequent ED utilization, medical costs, criminal behavior, disability, and death by patients with drug and alcohol problems of all severity level; and,
- Involve a multitude of perspectives to explore systems change to improve existing linkages to these services, and to expand substance abuse services to include early intervention.

As a result of the grant, chemical dependency professionals (CDPs) are now working in hospital emergency rooms in Seattle, Tacoma, Everett, Yakima, Toppenish, and Vancouver to screen and refer patients. WASBIRT is expected to provide services to 122,905 people during the period of the grant at Harborview Medical Center, Tacoma General Hospital, Providence Everett Medical Center, Yakima Regional Medical and Heart Center, Toppenish Community Hospital, and Southwest Washington Medical Center.

Through March 2005 (12 months after the first patient screening), 10,522 had received services through WASBIRT. Of these, 4943, representing 47%, were screened, but no further action was needed; 4,911 (47%) received a brief intervention in the hospital; 422 (4%) received a brief intervention plus several brief therapy sessions; and 246 (2%) either received chemical dependency treatment, or were referred for further assessment and treatment.

“Teachable Moments”

In some ways, EDs and trauma centers are ideal sites in which to provide people who drink or use illicit drugs in harmful or hazardous patterns with a targeted intervention at the time of an adverse event—a situation sometimes referred to as a “teachable moment.” The WASBIRT program extends beyond the brief intervention model by providing timely and appropriate referral to more intensive substance abuse treatment where appropriate.

Prior research has shown this to be an effective approach. A 2001 study showed that of 719 patients provided a direct referral to substance abuse treatment over a one-year period, some 80% made contact with the treatment facility, and 78% were admitted to treatment. The negative consequences associated with an ED visit often serve as prime motivators to move patients toward dealing with their substance abuse problems.

It is anticipated that implementation of screening, brief intervention, and referral will result in better health outcomes for patients, and will benefit participating hospitals and communities impacted by these services. Participating hospitals should experience a decrease in hospital ED admissions and hospital admissions caused by use and abuse of alcohol and other drugs and reduced costs associated with those admissions. Communities should be safer, as fewer injury-related events associated with substance abuse are likely to occur. A 1999 study found that within six months of ED brief interventions for alcohol-related problems among older adolescents, there was a 27% reduction in drinking and driving, an 87% reduction in moving violations, and a 58% reduction in alcohol-related injuries.⁴





Missed Opportunities

While EDs provide an excellent venue for intervening in a patient's substance abuse, the visit to the ED is often late in the chain of opportunities for such intervention. Multiple studies have demonstrated the efficacy of brief intervention in a variety of settings, most notably primary care offices and health care clinics.⁵

Often, however, those opportunities are missed. A 2000 survey of primary care physicians and patients published by the National Center on Addiction and Substance Abuse at Columbia University found that 94% of primary care physicians misdiagnose or fail to diagnose substance abuse when presented with early symptoms of alcohol abuse in adult patients. Only 19.2% of physicians felt themselves "very prepared" to diagnose alcoholism, and the percentage was lower for illegal drugs (16.9%). Fewer than a third (32.1%) of primary care physicians screen for substance abuse. Reasons cited for physicians failing to make use of intervention opportunities include: lack of adequate training in medical school or continuing education; lack of knowledge of treatment effectiveness; discomfort discussing substance abuse; time constraints; and patient resistance.⁶ A 2004 study found that, of the 7% of patients admitted to hospitals who had indications of alcohol disorders, fewer than half were so diagnosed in their hospital records.⁷

Future Challenges

DASA will continue to pursue opportunities to expand the WASBIRT model into additional EDs and trauma care centers. At the same time, hospitals, health insurers, and health maintenance organizations would do well to examine the cost offsets associated with providing screening, brief intervention, and treatment services for all individuals who enter EDs. It is likely that the cost of training of physicians and other health care professionals to provide appropriate interventions and referrals would be more than offset by decreased ED and hospital utilization.

There is also a substantial need for improved training of health care providers, both in their initial, residency, and continuing educations, on issues related to substance abuse. County medical associations could play an important role in facilitating the education of health care providers about the impact of brief interventions and the availability of community-based treatment resources.

Perhaps most important are efforts to mitigate the effects of stigma on patients, providers, and health care systems. Once substance abuse prevention and treatment efforts are considered part of larger array of health care services, and regularly provided as appropriate, it is likely that overall health care costs will be significantly reduced, and the health of individuals, families, and communities will be significantly enhanced.

¹ Center for Substance Abuse Treatment. *Alcohol and Other Drug Screening of Hospitalized Trauma Patients*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. TIP 16, 1995.

² Alden, J., Wang, N., & Camargo, C. "U.S. Emergency Department Visits for Alcohol-Related Diseases and Injuries Between 1992 and 2000," *Archives of Internal Medicine*, 164(5), March 2004.

³ Gentilello, L., et al. "Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence," *Annals of Surgery* 230(4), October 1999.

⁴ Monti, P., et al. "Brief Intervention for Harm Reduction with Alcohol-Positive Older Adolescents in a Hospital Emergency Department," *Journal of Consulting and Clinical Psychology* 67(6), 1999.

⁵ Fleming, M., et al. "Brief Physician Advice for Problem Alcohol Drinkers," *Journal of the American Medical Association* Vol. 277, 1997.

⁶ The National Center on Addiction and Substance Abuse at Columbia University. *Missed Opportunity: The CASA National Survey of Primary Care Physicians and Patients*. New York, NY: 2000.

⁷ Smothers, B., Yahr, H., & Ruhl, C. "Detection of Alcohol Use Disorders in General Hospital Admissions in the United States," *Archives of Internal Medicine*, 164(7), April 2004.

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College Drinking: Questioning the Myths

Drinking at colleges and universities is a major issue, taking its toll on youth in deaths, injuries, assaults, sexual abuse, unsafe sex, and academic problems. Students perceive peer alcohol use to be higher than it actually is. This misperception is a leading contributing factor in young people deciding to engage in high-risk drinking. Countering student misperceptions is one strategy shown to be effective among at-risk drinkers.

Consequences related to alcohol use on college and university campuses are a much more serious problem than many people realize. The issue has received much attention over the past few years. Tragic events at Washington State colleges and universities are covered in national media and elicit responses from elected officials and school administrators. Yet, between these isolated events, including student riots, collapsing decks, or fires at parties, there are daily deaths and injuries affecting our young people.

With so much recent attention on this issue, one might think that excessive drinking on campus is a new problem. In fact, campus drinking rates have been studied since the 1950's. The cultural expectation is that when one reaches college, it is not only permissible to drink, even if under 21, but that it is the norm and a rite of passage. Students come to college expecting that they will be drinking and that most of their peers will be drinking as well.

To address this norm, there is a national movement of colleges and universities to deal with the problems of alcohol and other drug abuse on campuses. In our state, the Washington State College Coalition for Substance Abuse Prevention brings together health professionals from campuses to work on this issue.

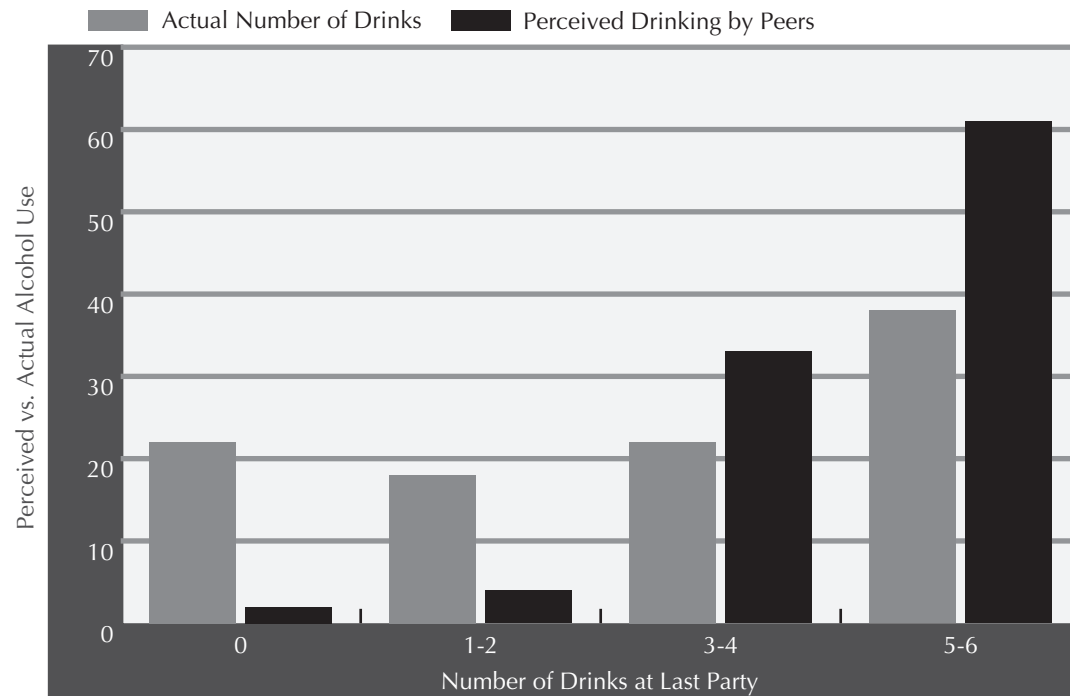
Before launching prevention strategies to address the problem of college drinking, it is necessary to define the patterns of

alcohol consumption occurring on campus. Rather than assuming that the national data holds true for students at Washington State colleges and universities, it was necessary to conduct a survey. In 2004, the College Coalition concluded the Washington Statewide Assessment (WASTA). The twofold purpose of the WASTA was to conduct a baseline assessment of (a) individual-level alcohol and other drug use among a sample of Washington State college students, and (b) campus- and community-level prevention practices among a sample of Washington State institutions of higher education, in order to plan and evaluate current and future capacities to implement evidence-based prevention strategies.¹

Results of the WASTA indicate that while levels of alcohol use on campus remain high, more students are reporting no alcohol use or moderate drinking. In fact, a small percentage of students who exhibit problem drinking behavior cause a disproportionate number of negative consequences for themselves and their peers. With the media attention and persistent norm that the college years are a time for heavy drinking, many students in Washington and the nation as a whole are misinformed about the reality of college alcohol use.

The survey conducted as part of WASTA found that students' perceptions of the frequency with which typical students use alcohol in the past 30 days greatly exceeds the actual reported frequencies of use. A pattern of misperception of peer alcohol use norms typifies students' responses on this scale, as indicated by the following:

- 17.8% report never using alcohol, but 0.9% believes that typical students would report that they had never used alcohol.
- 0.3% report using alcohol every day, but 31.8% believe that typical students use alcohol every day.²

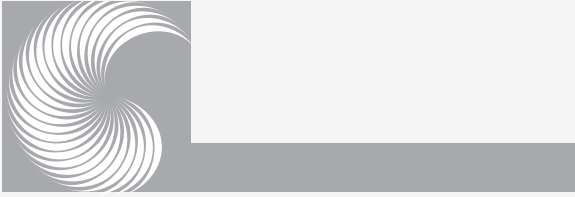


Source: Fabiano, P. et al., *Washington Statewide Assessment of College Student Alcohol and Other Drug Use and Consequences and Campus - and Community-Based Prevention Practices*: 2004.

Students greatly underestimate the number of their peers that abstain or drink in moderation and greatly overestimate the number of their peers that drink heavily. Students in the WASTA sample greatly overestimate the percentage of their peers who engage in frequent, heavy drinking. While less than one percent of students report daily use of alcohol, 31.8% of students believe their peers drink daily. Conversely, while 31.6% have chosen never to use alcohol or have not used in the past 30 days, 0.9% believe their peers would choose not to drink.³

Unfortunately, the persistent myth that excessive drinking is the norm is a leading contributing factor in young people deciding to engage in high-risk drinking. There are well-established relationships between the level of alcohol consumption and increased risks for negative consequences.^{4,5} For those students that do engage in excessive drinking, there is a markedly higher incidence of negative consequences.

Nationally, alcohol use by students results in a staggering level of negative consequences. As reported on CollegeDrinkingPrevention.gov, these consequences affect



not only the drinker, but their peers and the members of the community. The consequences include:

- **Death:** 1,400 college students ages 18-24 die each year from alcohol-related unintentional injuries, including motor vehicle crashes.⁶
- **Injury:** 500,000 students ages 18-24 are unintentionally injured under the influence of alcohol.⁷
- **Assault:** More than 600,000 students ages 18-24 are assaulted by another student who has been drinking.⁸
- **Sexual Abuse:** More than 70,000 students ages 18-24 are victims of alcohol-related sexual assault or date rape.⁹
- **Unsafe Sex:** 400,000 students ages 18-24 had unprotected sex and more than 100,000 students between the ages of 18 and 24 report having been too intoxicated to know if they consented to having sex.¹⁰
- **Academic Problems:** About 25% of college students report academic consequences of their drinking including missing class, falling behind, doing poorly on exams or papers, and receiving lower grades overall.^{11 12 13 14}
- **Health Problems/Suicide Attempts:** More than 150,000 students develop an alcohol-related health problem¹⁵ and between 1.2 - 1.5% of students indicate that they tried to commit suicide within the past year due to drinking or drug use.¹⁶
- **Drunk Driving:** 2.1 million students ages 18-24 drove under the influence of alcohol last year.¹⁷
- **Alcohol Abuse and Dependence:** 31% of college students met criteria for a diagnosis of alcohol abuse and 6% for a diagnosis of alcohol dependence in the past 12 months, according to questionnaire-based self-reports about their drinking.¹⁸

Addressing Campus Drinking

To assist in applying appropriate methods, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) divides prevention strategies for college students into three tiers.¹⁹

Tier 1. Strategies Effective Among College Students. The strategies in this tier have been shown to be effective among alcohol-dependent drinkers, problem drinkers, and students whose drinking patterns place them at increased risk for developing alcohol problems. Strong evidence supports the effectiveness of the following strategies: 1. Simultaneously addressing alcohol-related attitudes and behaviors (e.g., refuting false beliefs about alcohol's effects while teaching students how to cope with stress without resorting to alcohol); 2. Using survey data to counter students' misperceptions about their fellow students' drinking practices and attitudes toward excessive drinking; and 3. Increasing students' motivation to change their drinking habits, for example by providing nonjudgmental advice and evaluations of the students' progress. Programs that combine these three strategies have proven effective in reducing alcohol consumption.²⁰

Tier 2. Strategies Effective Among the General Population That Could Be Applied to College Environments. These strategies have proven successful in populations similar to those found on college campuses. Measures include: 1. Increasing enforcement of minimum legal drinking age laws;²¹ 2. Implementing, enforcing, and publicizing other laws to reduce alcohol-impaired driving, such as zero-tolerance laws that reduce the legal blood alcohol concentration for underage drivers to near zero;²² 3. Increasing the prices or taxes on alcoholic beverages;²³ and 4. Instituting policies and training for servers of alcoholic beverages to prevent sales to underage or intoxicated patrons.^{24 25}



Tier 3. Promising Strategies That Require Research. These strategies make sense intuitively or show theoretical promise, but more comprehensive evaluation is needed to test their usefulness in reducing the consequences of student drinking. They include more consistent enforcement of campus alcohol regulations and increasing the severity of penalties for violating them; regulating happy hours; enhancing

awareness of personal liability for alcohol-related harm to others; establishing alcohol-free dormitories; restricting or eliminating alcohol-industry sponsorship of student events while promoting alcohol-free student activities; and conducting social norms campaigns to correct exaggerated estimates of the overall level of drinking among the student body.

¹ Fabiano, P., et al. M. *Washington Statewide Assessment of College Student Alcohol and Other Drug Use and Consequences and Campus- and Community-Based Prevention Practices*: 2004.

² Ibid.

³ Ibid.

⁴ Midanik L., et al. "Risk Functions for Alcohol-Related Problems in a 1988 U.S. National Sample. *Addiction* 91, 1996.

⁵ Bondy S., et al. "Low-Risk Drinking Guidelines: The Scientific Evidence", *Canadian Journal of Public Health* 90(4), 1999..

⁶ Hingson, R., et al. Magnitude of Alcohol-Related Mortality and Morbidity Among U.S. College Students Ages 18–24", *Journal of Studies on Alcohol* 63(2), 2002.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Engs, R., et al. "The Drinking Patterns and Problems of a National Sample of College Students, 1994", *Journal of Alcohol and Drug Education* 41(3), 1996.

¹² Presley C., Meilman, P. and Cashin, J. *Alcohol and Drugs on American College Campuses: Use, Consequences, and Perceptions of the Campus Environment, Vol. IV: 1992-1994*. Carbondale, IL: Core Institute, Southern Illinois University, 1996a.

¹³ Presley, C., et al. *Alcohol and Drugs on American College Campuses: Use, Consequences, and Perceptions of the Campus Environment, Vol. III: 1991-1993*. Carbondale, IL: Core Institute, Southern Illinois University, 1996b.

¹⁴ Wechsler, H., et al. "Trends in College Binge Drinking During a Period of Increased Prevention Efforts: Findings from Four Harvard School of Public Health Study Surveys, 1993-2001", *Journal of American College Health* 50(5), 2002.

¹⁵ Hingson, R. op. cit.

¹⁶ Presley, C. Lechlitter, M., and Meilman, P., *Alcohol and Drugs on American College Campuses: A Report to College Presidents: Third in a Series, 1995, 1996, 1997*. Carbondale, IL: Core Institute, Southern Illinois University, 1998.

¹⁷ Hingson, R. op. cit.

¹⁸ Knight, J., et al., "Alcohol Abuse and Dependence Among U.S. College Students. *Journal of Studies on Alcohol* 63(3), 2002.

¹⁹ National Institute on Alcohol Abuse and Alcoholism. *Alcohol Alert* #58, October 2002. <http://www.niaaa.nih.gov/publications/aa58.htm>

²⁰ Larimer, M., & Cronce, J. "Identification, Prevention, and Treatment: A Review of Individual-Focused Strategies to Reduce Problematic Alcohol Consumption by College Students", *Journal of Studies on Alcohol*, Suppl.14, 2002.

²¹ Wagenaar, A., & Toomey, T., "Effects of Minimum Drinking Age Laws: Review and Analyses of the Literature from 1960 to 2000", *Journal of Studies on Alcohol* Suppl. 14, 2002.

²² Wagenaar, A., O'Malley, P. and LaFond, L. "Lowered Legal Blood Alcohol Limits for Young Drivers: Effects on Drinking, Driving, and Driving-After-Drinking Behaviors in 30 States", *American Journal of Public Health* 91(5), 2001.

²³ Cook, P. & Moore, M. "The Economics of Alcohol Abuse and Alcohol-Control Policies", *Health Affairs* 21(2), 2002.

²⁴ Toomey, T., & Wagenaar, A. "Environmental Policies to Reduce College Drinking: Options and Research Findings", *Journal of Studies on Alcohol* Suppl. 14, 2002.

²⁵ Holder, H., et al. "A Community Prevention Trial to Reduce Alcohol-Involved Accidental Injury and Death: Overview. *Addiction* 92(Suppl. 2), 1997.

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Recognition of the close links between substance abuse and child abuse and neglect is growing. Yet, access to chemical dependency treatment for parents with children in the child welfare system remains difficult. The Division of Alcohol and Substance Abuse is now working with the Children's Administration to foster greater understanding and improve collaboration between the substance abuse prevention and treatment and child welfare systems.

Child Maltreatment 2003, a report issued by the U. S. Department of Health and Human Services, Administration for Children & Families, Children's Bureau, indicates there were an estimated 906,000 confirmed victims of child abuse or neglect in 2003, a rate of 12.4 per 1,000 children in the national population. Among maltreated children, 61% experienced neglect; 19% were physically abused; and 10% sexually abused. An estimated 1,500 fatalities were attributed to child abuse and neglect.¹ Every day hundreds of thousands of young people suffer the effects of family dysfunction, violence, homelessness, crime, and poverty that result from living in a household impacted by substance abuse. Experts agree there is a strong, frequently occurring correlation between parental chemical dependency and child abuse and neglect.

A 1999 report from the National Center on Addiction and Substance Abuse at Columbia University found that parental substance abuse causes or exacerbates seven out of ten cases of child abuse and neglect, and results in \$20 billion annually in federal, state, and local government spending. Children whose parents abuse drugs or alcohol are three times more likely to be abused and four times more likely to be neglected than are children of parents who are not substance abusers.²

In Washington State, the federal 2004 Child and Family Services Review found that substance abuse is the primary reason for opening 10% of the child welfare cases reviewed.

Substance Abuse and Child Welfare

Substance abuse was cited in 34% of the cases as the reason for children coming to the attention of the Washington Child Protective Services.³

Two Different Systems

The child protective services system and substance abuse prevention and treatment field operate with different goals, philosophies and mandates. The highest priority of the child welfare system is to provide immediate protection for children, often beginning by removing the child from immediate risk of harm. Secondary goals are to move children into a stable environment as quickly as possible, and then, once the risk in the original home is eliminated, to attempt family reunification. Chemical dependency treatment, in contrast, is directed at assisting clients (the parents) in controlling a chronic disease condition and helping them move through what is often a slow process of recovery.

Furthermore, accessing chemical dependency treatment in a timely manner remains difficult. Nationally, 67% of the parents with children in the child welfare system require chemical dependency treatment, but the child welfare agencies are able to ensure treatment for only 31% of them. Complicating matters still further is the difficulty in getting child welfare workers, already burdened by large caseloads, to document the impact of parental substance abuse on parenting and family functioning, for which they are not fully trained.

The 2004 Child and Family Services Review final report determined that there is a critical gap in service array in Washington State, particularly in the areas of mental health and substance abuse treatment. In addition, while research has shown that consistent exposure to parental abuse of alcohol and other drugs may contribute to the development of a child's own substance abuse problems, there is often a critical lack of targeted developmentally appropriate substance abuse



prevention services for children of chemically dependent parents. In short, there is much work yet to be done.

Future Directions

Staff from both systems should be provided with opportunities to learn about the other system. Training should include content on the interrelatedness of substance abuse and forms of family violence, such as child abuse and neglect. The substance abuse treatment workers need to have a better understanding of the child welfare system and the importance of family dynamics in support of reunification. In addition, child welfare workers need to have a better understanding of addiction and the recovery process. It is also important to increase interagency communication and collaboration between the two systems, working together with the client's best interest in mind. Case conferences should include all of the individuals who are working with the family. This includes sharing information and concerns about the clients.

The costs of parental AOD use are incalculable and the scars of drug-and alcohol-spawned parental abuse and neglect is likely to be permanent. Through increased collaboration, education, and information sharing both the child welfare system and chemical dependency system will be better able to serve the families impacted by AOD.

Recognizing common challenges and opportunities, in January 2005, the Washington State Division of Alcohol and Substance Abuse (DASA) and the Children's Administration (CA) signed an interagency agreement to improve access to and use of chemical dependency treatment services for families, and prevention services for youth. Included in the

agreement are commitments to develop a comprehensive and collaborative training plan to foster greater understanding of alcohol/drug-related issues, earlier identification of substance abuse, and more systematic intervention, including screening and treatment referral.

During the 2005 Legislative Session, Senate Bill 5763 was passed to require the Department of Social and Health Services (DSHS) to provide chemical dependency specialist services at each of the 44 Division of Children and Family Services (DCFS) offices. The purpose is to enhance the timeliness and quality of Child Protective Services (CPS) assessments and to better connect families to needed treatment services. The 20 new chemical dependency specialists' duties may include, but are not limited to, conducting on-site chemical dependency screening and assessment, facilitating progress reports to department social workers, in-service training of DCFS social workers and staff on substance abuse issues, referring clients from DCFS to treatment providers, and providing consultation on specific cases. In addition, DSHS will ensure that each case-carrying social worker is trained in uniform screening for mental health and chemical dependency.

In April 2005, a three-month project in the DCFS office in Yakima County is piloting the use of the UNCOPE, a screening instrument. The six-question tool provides a simple and quick means of identifying whether the person is at risk for abuse or dependence for alcohol and other drugs. If the CPS social worker identifies an individual through the UNCOPE screening as needing further assessment for substance abuse, the client is referred to the chemical dependency specialist located at the CPS office. This pilot project is being collaboratively evaluated by DASA and CA.

¹ Children's Bureau. *Children Maltreatment 2003*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, 2005.

² Reid, J., Macchetto, P., and Foster, S. *No Safe Haven: Children of Substance-Abusing Parents*. New York, NY: National Center on Addiction and Substance Abuse at Columbia University, 1999.

³ Children's Bureau. *Child and Family Services Review—Washington State*. Washington, DC: U.S. Department of Health and Human Services Administration for Children and Families Administration on Children and Families Administration on Children, Youth and Families, Children's Bureau, 2004.

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The Use of Medications in Addiction Treatment

Medications can play an important role in the treatment of alcohol and other drug addiction and relapse prevention. Three new medications – naltrexone, acamprosate, and Suboxone – are particularly promising. When indicated, medications for the treatment of alcohol and drug addiction work best used in tandem with psychosocial interventions.

The New Medications

Over the past ten years, several new medications have become available which have demonstrated effectiveness in the treatment of alcohol or drug addiction, and in relapse prevention. There are three of particular importance: naltrexone, in both its short and long acting forms, acamprosate; and Suboxone. In the past, many treatment professionals have resisted the use of medications beyond acute detoxification in the treatment of addictions. This is understandable, given the somewhat checkered history of medications which, though promised to be non-abusable, have ended up significantly abused, such as certain benzodiazepines, and, more recently, opiates for “pain management.” However, it would be short-sighted for Washington State addiction treatment personnel to not examine both the cost and benefits of the use of medications on a case-by-case basis. The above three medications have all received Federal Drug Administration approval for the treatment of addictions or relapse prevention, and all have been highly scrutinized.

Naltrexone

Naltrexone or Revia®, is not actually new. It was developed as an opiate receptor blocker many years ago and has been used in treatment programs as an opiate antagonist for persons who have become dependent on opiates, especially with recovering anesthesiologist physicians. Clinical observation in some patients taking naltrexone revealed

that certain patients who also used alcohol seemed to drink less and reported that it affected them less. This resulted in a number of randomized clinical trials in the early 1990’s, which in most cases showed that, in specific alcohol-dependent populations, patients who took oral naltrexone drank less and for fewer days. A new development around naltrexone has been the production of a long-acting injectable form that can be given monthly. Findings from a recent study indicate that, even in relatively unmotivated alcohol-dependent patients, there were significantly fewer days of drinking and, when drinking happened, less was consumed, although rates of complete abstinence were not greater than placebo. This appears to be the emerging clinical profile of naltrexone, which may be best seen more as a “harm reduction” aid rather than a “complete abstinence” treatment enhancer.

Side Effects and Potential Toxicities: The main side effects observed with naltrexone are mild to moderate nausea, and at times, vomiting, especially during the first week or two of use. Some patients also experience mild to moderate dysphoria. Since naltrexone is an opiate receptor blocker, if persons need to take opiates for acute pain relief, the opiates either will be ineffective, or a markedly increased dose of them will need to be given.

Dosage: Naltrexone is usually started at 25mg per day and over the next few weeks moved to either 50, 75, or 100mg per day. It is covered for six months by Medicaid, provided the person is involved in a certified addiction treatment program. DASA has been flexible in approving its use for patients with co-occurring disorders involved at a mental health center. The new, one-a-month injectable form appears especially effective, and should be available clinically soon. The cost of the medication ranges from about \$3-8 per day, depending on dosage.



Acamprosate

Acamprosate (brand name, Campral®), which is made by Forest Pharmaceuticals, was released in the United States in early 2005 with FDA approval for the maintenance of abstinence from alcohol dependence. Acamprosate has been available in a variety of European and other countries for over ten years. Unlike naltrexone which works as a blocker of the opiate receptor, acamprosate appears to work by stabilizing the balance between the inhibitory-GABA system and the excitatory-glutamate/NMDA system. With chronic alcohol dependence, the excitatory system appears to upregulate in order to deal with the chronic onslaught of alcohol on the inhibitory GABA system. It is thought that acamprosate works by stabilizing this system.

Side Effects and Potential Toxicities: Acamprosate interacts with almost no other medications, vital functions, vital signs, or other body systems. It is excreted only in the urine and is not metabolized in the liver. It is thus safe for patients with significant liver impairments, unlike Antabuse® or naltrexone, which are liver-metabolized. In large studies, the only side effect slightly more common than with placebo was mild diarrhea in the first two weeks of use. It has not been found either safe or toxic in pregnancies, and thus should be stopped if a woman becomes pregnant while taking it. It has no effect on euphoria or mood, and does not cause any kind of tolerance or withdrawal symptoms, whether patients use it alone or along with alcohol. There is at present no demonstrated effectiveness with acamprosate for addictions other than alcohol dependence.

Dosage: Due to the way it is absorbed, acamprosate must be taken as two pills three times a day, with each dosage period separated by at least four hours. It is recommended that patients take the medicine continuously for at least three months, whether they relapse or not, and then use is renegotiated. Unlike the injectable naltrexone, acamprosate

has not been shown effective in patients with less than moderate motivation to be abstinent. The strongest findings from the outcome studies indicate that acamprosate is most effective in increasing complete abstinence from alcohol, or increasing the time before the first drink. The cost of acamprosate is approximately \$120 per month. It is also covered by Medicaid for up to one year if a person is enrolled in a certified chemical dependency treatment program, seeing a licensed addiction provider, or is in a mental health-based co-occurring disorders program.

Suboxone

Suboxone is a combination medication composed of the mixed opiate agonist-antagonist buprenorphine and the antagonist naloxone. Its sole indication is for the treatment of opiate dependence, and it is classified as an opiate substitution medication.

It is hoped that the use of buprenorphine-based Suboxone will allow for a broader array of opiate dependent patients to seek and enroll in some sort of addiction treatment. Studies have shown many opiate addicts refuse the rigor of daily dosing and urine tests at methadone clinics, though certainly, without this degree of contact and rigor of treatment, there would be no hope for many. On the other hand, those with milder opiate dependence, or those who may have been on methadone for some years, may desire a less monitored atmosphere. They may prefer a weekly or even monthly dispersal of Suboxone and attend Narcotics Anonymous or weekly addiction counseling, especially if they are working and have a family. It is also hoped that buprenorphine, with its mixed activity at the opiate receptor, may allow for more patients who may have had longer term opiate dependency to gradually taper their medication and potentially adopt a totally drug free lifestyle. Whether this in fact will turn out to be the case remains to be seen.



Side effects and potential toxicities: For most patients, Suboxone has few if any side effects. Because it tightly attaches to the opiate receptor, if patients need to take opiates for pain relief for acute surgery or other reasons, either it has to be stopped or markedly increased doses of the opiate need to be given. If patients have been on methadone, especially at doses over 30mg per day within the last two weeks, induction onto Suboxone is often problematic because buprenorphine will kick methadone off the opiate receptor, inducing a minor or even a major withdrawal syndrome. Thus, if moving from methadone onto Suboxone, patients should taper down on methadone to the lowest possible dose, then wait for longest period into active withdrawal before being induced using small doses of Suboxone, generally 2-4mg. Most heroin addicts can be easily dosed onto Suboxone by giving them 2-8mg sublingually approximately 15-20 hours after their last heroin use while they are in significant withdrawal. Dosage adjustment up to the usual standard daily doses of 12-24mg (range 2-32mg) sublingually per day should happen over the first few days.

The Suboxone combination of buprenorphine and naloxone is directed at preventing diversion of the medication for illicit intravenous use. Use of Suboxone intravenously would result in immediate and serious withdrawal. When taken sublingually, little of the naloxone is absorbed, while most of the buprenorphine is absorbed. The sublingual dose goes directly into the circulatory system without needing to pass through the liver, and is thus more effective.

There appears to be a small street market for diverted Suboxone. Anecdotally it is reported that Suboxone may be used by those addicted to heroin to detoxify themselves. Suboxone has also been evaluated as an acute detoxification agent for persons coming into hospitals or detox centers with opiate dependence. Though much of the research evaluation of this aspect of the medication's use remains to be published, early pilot study experience suggests that it can be effectively used this way. The cost of Suboxone is approximately \$4-16 per day, depending on dosage. It is covered by Medicaid for six months, providing the person is enrolled in a certified addiction treatment program.

In Tandem

Pharmacological aids definitely have a place in the treatment of alcohol and other drug addiction. They are not substitutes for psychosocial interventions, and the two work best in tandem. Just as it might be hoped that medical professionals will become more open to using psychosocial and even spiritual interventions in helping patients with chronic medical illness to restore and maintain better health and functioning, it is also to be hoped chemical dependency professional will be supportive of assisting patients to use medications in treatment and prevention as appropriate.

*Prepared by Richard Ries, M.D., Medical Director,
Washington State Division of Alcohol and Substance Abuse*

Data Sources



DATA SOURCES



Data Sources

Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State – 2005 contains information and data from a wide variety of federal and state government agencies. Given the diverse indicators included in this Report, data sources differ significantly with regard to methodology, sampling and collection procedures, as well as in the reliability and validity of the data. Report users are encouraged to consult the original data sources for more detailed information.

National Sources

Monitoring the Future (MTF) (www.isr.umich.edu/src/mtf)

Conducted by the Institute for Social Research, University of Michigan, and supported by research grants from the National Institute on Drug Abuse, the Monitoring the Future (MTF) project studies changes in the beliefs, attitudes, and behavior of young people in the United States. Surveys have been carried out each year since 1975. Students in the 8th, 10th, and 12th grades complete self-administered, machine-readable questionnaires in their classrooms. Surveys are administered from February to May, invalidating direct comparisons with results from a similar survey – the Washington State Health Youth Survey – which is administered in October. Data are used to monitor trends in substance use and abuse among adolescents, and progress toward national education goals for safe, disciplined, and alcohol- and drug-free goals. Results are also used in development of the White House National Drug Control Strategy.

National Institute on Drug Abuse (NIDA) (www.nida.nih.gov/)

The mission of the National Institute on Drug Abuse (NIDA) is to lead the nation in bringing the power of science to bear on drug abuse and addiction. NIDA seeks to accomplish this mission through the strategic support and conduct of research across a broad range of disciplines. NIDA supports over 85% of the world's research on health-related aspects of drug abuse and addiction. NIDA also works to ensure the rapid and effective dissemination and use of results from research to significantly improve drug abuse and addiction prevention, treatment, and policy. NIDA is one of the 19 institutes that comprise the National Institutes of Health (NIH).

National Institute on Alcohol Abuse and Alcoholism (NIAAA) (www.niaaa.nih.gov/)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is one of 19 institutes that comprise the National Institutes of Health (NIH), the principal biomedical research agency of the federal government. NIAAA provides leadership in the national effort to reduce alcohol-related problems by:

- Conducting and supporting research in a wide range of scientific areas including genetics, neuroscience, epidemiology, health risks and benefits of alcohol consumption, prevention, and treatment;
- Coordinating and collaborating with other research institutes and federal programs on alcohol-related issues;
- Collaborating with international, national, state, and local institutions, organizations, agencies, and programs engaged in alcohol-related work; and



Data Sources

- Translating and disseminating research findings to health care providers, researchers, policymakers, and the public.

NIAAA-supported research and direction are aimed at:

- Removing the stigma associated with the common complex disease of alcoholism;
- Revealing genetic, other biological, and sociocultural origins of variations in individual responses to alcohol and the consequent risks and benefits of alcohol to health;
- Developing effective prevention and treatments that address the physical, behavioral, and social risks attributable to excessive and underage alcohol consumption, and the chronic relapsing nature of alcoholism; and
- Improving the acceptance of, and access to, quality care.

Bureau of Justice Statistics (BJS) (www.ojp.usdoj.gov/bjs/)

The Bureau of Justice Statistics (BJS), part of the Office of Justice Programs within the U.S. Department of Justice, is the nation's leading source from criminal justice-related data. BJS collects, analyzes, publishes, and disseminates data on crime, criminal offenders, victims, of crime, and the operation of, and expenditures related to, justice systems at all levels of government. These data are used by federal, state, and local policymakers.

Annually, BJS publishes *Bureau of Justice Statistics Key Crime Statistics at a Glance*, a summary of information and data most recently gathered. This report can be found at www.ojp.usdoj.gov/bjs/glance.htm#Crime.

Federal Bureau of Investigation – Uniform Crime Reports (www.fbi.gov/ucr/ucr.htm)

The Federal Bureau of Investigation's (FBI) Uniform Crime Reporting Program (UCR) collects crime statistics from nearly 17,000 law enforcement agencies across the United States, covering approximately 95% of the population. Data are gathered by state and local agencies and submitted to the FBI. Data related to eight categories of crime are gathered: 1) murder and nonnegligent manslaughter; 2) forcible rape; 3) robbery; 4) aggravated assault; 5) burglary; 6) larceny-theft; 7) motor vehicle theft; and 8) arson.

The primary limitation of UCR is that it measures reported crime rather than all crimes committed. Reported levels may vary from community to community as a result of a wide variety of factors, including funding and aggressiveness of local law enforcement agencies. The FBI operates two other reporting systems. The National Crime Victimization Survey collects data on unreported as well as reported crime by surveying a representative sample of households. The National Incident-Based Reporting Systems presents comprehensive, detailed information about crime incidents to law enforcement, researchers, and planners.



Data Sources

Centers for Disease Control and Prevention (CDC) (www.cdc.gov)

The federal Centers for Disease Control and Prevention (CDC) is the lead federal agency charged with protecting the health and safety of Americans, providing information for making health decisions, and promoting and protecting the nation's health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control strategies, environmental health approaches, and health promotion and education activities. There are 11 national centers.

National Center for Injury Prevention and Control (NCIPC) (www.cdc.gov/ncipc/)

The National Center for Injury Prevention and Control (NCIPC) works to reduce morbidity, disability, mortality, and costs associated with injuries occurring outside the workplace. One of the federal Centers for Disease Control and Prevention, NCIPC conducts and supports research about causes, risk factors, and preventive measures for injuries outside the workplace, including:

- Unintentional injuries related to falls, fires, drowning, poisoning, motor vehicle crashes (including those involving pedestrians), sports and recreational activities, and playgrounds and day-care settings;
- Intentional injuries related to homicide, suicide, youth violence, intimate partner violence, child maltreatment, and sexual violence; and
- Improving health and quality of life after injuries and preventing secondary conditions among people with disabilities.

NCIPC also funds research by universities and other public and private groups studying the three phases of injury control (prevention, acute care, and rehabilitation) and the two major disciplines of injury control (epidemiology and biomechanics).

HIV/AIDS Surveillance Report (www.cdc.gov/hiv/stats/hasrlink.htm)

The HIV/AIDS Surveillance Report is published annually by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, CDC. It contains data about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, gender, race/ethnicity, age, vital status, and case definition category.

National Center for HIV, STD, and TB Prevention (NCHSTP) – Division of Sexually Transmitted Diseases (www.cdc.gov/nchstp/od/nchstp.html)

CDC's Division of Sexually Transmitted Diseases (STDs) provides national leadership through research, policy development, and support of effective services to prevent STDs (including HIV infection) and their complications, such as enhanced HIV transmission, infertility, adverse outcomes of pregnancy, and reproductive tract cancers. The Division assists health departments, health care providers, and non-governmental organizations and collaborates with other governmental entities through the development, syntheses, translation, and dissemination of timely, science-based information; the development



Data Sources

of goals and science-based policy; and the development and support of science-based programs that meet the needs of communities.

National Center for HIV, STD, and TB Prevention (NCHSTP) – Division of Tuberculosis Elimination (www.cdc.gov/nchstp/tb/surv/surv.htm)

The NCHSTP Division of Tuberculosis Elimination (DTBE) seeks to provide leadership in preventing, controlling, and eventually eliminating tuberculosis (TB) in the U.S., in collaboration with partners at the community, state, and international levels. To accomplish this mission, the DTBE carries out the following activities:

- Develops and advocates effective and appropriate TB prevention and control policies;
- Supports a nationwide framework for monitoring TB morbidity and mortality;
- Detects and investigates TB outbreaks;
- Conducts clinical, epidemiological, behavioral, and operational research to enhance TB prevention and control efforts;
- Evaluates prevention effectiveness;
- Provides funding and technical assistance to state and local health departments; and
- Provides training, education, and technical information services to state and local health departments.

DBTE publishes an annual TB Surveillance Report. The reports include statistics on tuberculosis case counts and case rates by states and metropolitan statistical areas with tables of selected demographic and clinical characteristics (e.g., race/ethnicity, age group, country of origin, form of disease, drug resistance, etc.)

Behavioral Risk Factor Surveillance System (BRFSS) (<http://www.cdc.gov/brfss>)

CDC's National Center for Chronic Disease Prevention and Health Promotion administers the Behavioral Risk Factor Surveillance System (BRFSS), the world's largest telephone survey. Based on an understanding that personal health behaviors play a major role in premature morbidity and mortality, BRFSS facilitates the collection of behavior-related data on a state-specific basis. State-level surveillance of prevalence of major behavioral risks assists states in planning, initiating, supporting, and evaluating health promotion and disease prevention programs.

National Center for Health Statistics (NCHS) (www.cdc.gov/nchs)

CDC's National Center for Health Statistics (NCHS) provides statistical information to be used by policymakers and health professionals to improve the health of the American people. As the nation's principal health statistics agency, NCHS is responsible for providing accurate, relevant, and timely data. NCHS has two major types of data systems: those based on



Data Sources

populations, containing data collected through personal interviews or examinations; and those containing data collected from vital and medical records.

National Highway Traffic Safety Administration – Fatality Analysis Reporting System (FARS) (www-fars.nhtsa.dot.gov)

The Fatality Analysis Reporting System (FARS) facilitates the collection and reporting of data for all fatal crashes involving automobiles in the United States, and provides a basis for evaluation of overall highway safety, motor vehicle safety standards, and highway safety initiatives and programs. FARS maintains cooperative agreements with agencies in each state to collect and report fatal crash data in a standard format. Data is available through a web-based “encyclopedia”.

Data Sources



State Sources

Washington State Department of Social and Health Services, Divisions of Alcohol and Substance Abuse - TARGET

TARGET (Treatment Assessment Report Generation Tool) is a reporting management information system used by the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Reporting is required for treatment agencies providing public sector-contracted/funded treatment services and optional for private pay individuals served. TARGET information collection is based on establishing a baseline at admission to treatment and capturing/identifying changes to that baseline upon discharge, thus providing information on progress during treatment.

Office of Financial Management – Population Trends for Washington State (<http://www.ofm.wa.gov>)

The Office of Financial Management (OFM) provides official population counts and estimates. Population figures reported by OFM include all persons who normally reside in the state, including military personnel and dependants, persons in correctional institutions, residents of nursing care facilities, and college students.

Washington State Department of Health – Center for Health Statistics (<http://www.doh.wa.gov/>)

Data used come from Certificates of Live Birth, Fetal Death, Death, Marriage, and Dissolution. Data for Washington State Vital Statistics are compiled for each year from certificates received before April 15 of the following year.

Washington State Department of Health, Office of Hospital and Patient Data System – Comprehensive Hospital Abstract Reporting System

The Washington State Department of Health's Comprehensive Abstract Reporting System (CHARS) monitors hospital admission trends, causes of hospitalization, and other indices used to evaluate the quality and accessibility of health care in Washington. Key data elements include patients' age, sex, physician, primary and secondary diagnoses, principal and secondary procedures, length of stay, and discharge status.



Data Sources

CHARS does not include data from federal, military and Veteran's Administration hospitals. Also excluded from the system are emergency room visits, data from outpatient facilities, surgery centers, birthing centers, and free-standing mental health, substance abuse, and rehabilitation centers or clinics.

Washington Traffic Safety Commission (<http://www.wa.gov/wtsc/index.htm>)

Collaboration among state, federal, and local partners is key in designing and implementing successful traffic safety programs. Each year the federal government allocates part of the federal Highway Trust Fund to the states to carry out highway safety programs. The Washington Traffic Safety Commission (WTSC) has administered these funds and facilitates these efforts in Washington State since 1967. Governor Christine Gregoire serves as WTSC chair. WTSC offers several programs, including the following: Impaired Driving, Community DUI & Traffic Safety Programs, Occupant Protection, Police, Traffic Records and Research, Youth, College-Age, Pedestrian/Bicycle, and Public Information and Education.

Washington State Survey of Adolescent Health Behaviors.

The Washington State Survey of Adolescent Health Behaviors (WSSAHB) provides information about the health attitudes and behaviors of Washington youth. A student survey has been conducted in Washington in even-numbered years since 1988, under the auspices of the Office of Superintendent of Public Instruction (OSPI). The WSSAHB includes a sample of public schools students in 6th, 8th, 10th, and 12th grades. The survey provides information on tobacco, alcohol and other drug use, violence, related risk and protective factors, and demographics (age, race, and gender).

Survey samples are selected using a stratified cluster sampling procedure, with schools being the primary sampling unit. Data from student surveys are useful for obtaining statewide estimates of the prevalence of health risk behaviors among youth, examining trends and patterns in risk behaviors, and establishing profiles of persons at risk. Caveats related to the data include:

- Students survey does not represent youth who have dropped out of school. It is thought to be likely that these youth are the most likely to engage in high-risk behavior.
- Health risk behaviors may be underestimated as it is self-reported. Willingness to self-report behavior is subject to social acceptability norms.
- Changes in time of year for survey administration means that students may differ in age and experience from survey to survey, and seasonality factors may affect results. In such instances (as in 2002), data may not be comparable with previous surveys or with national surveys conducted at a different time of year.

DASA in Brief: 2005 - 2007 Biennium

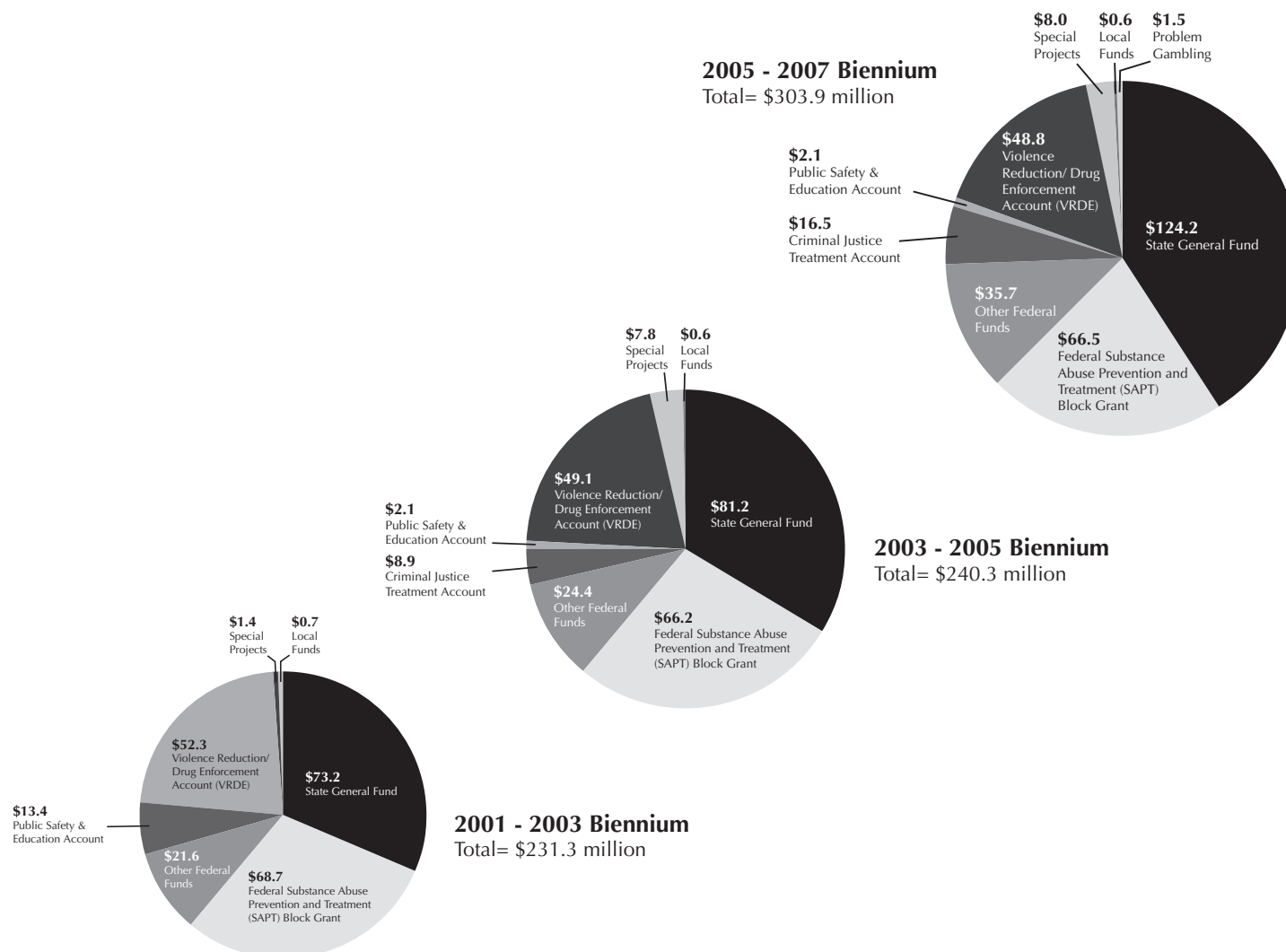


DASA in Brief



The Division of Alcohol and Substance Abuse's 2005-2007 Budget

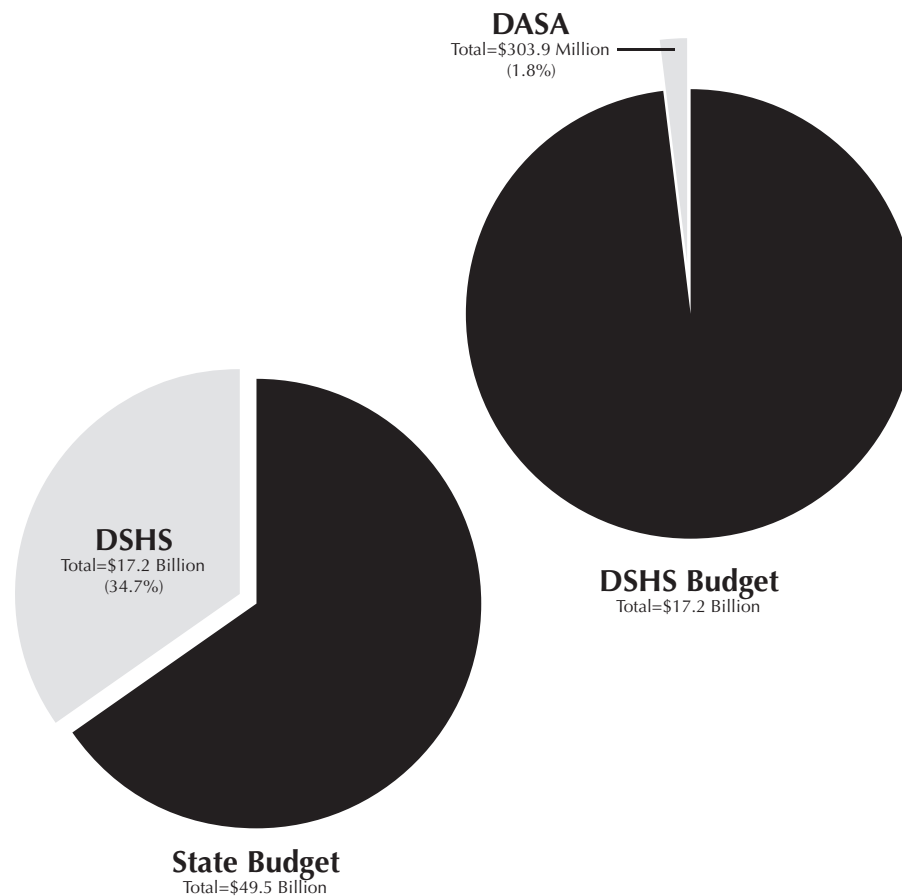
DASA's projected 2005-2007 Biennium Budget of \$303.9 million represents a 26.5% increase over 2003-2005.



The Division of Alcohol and Substance Abuse's 2005-2007 Biennium Budget is a Small Fraction of that of the Department of Social and Health Services.

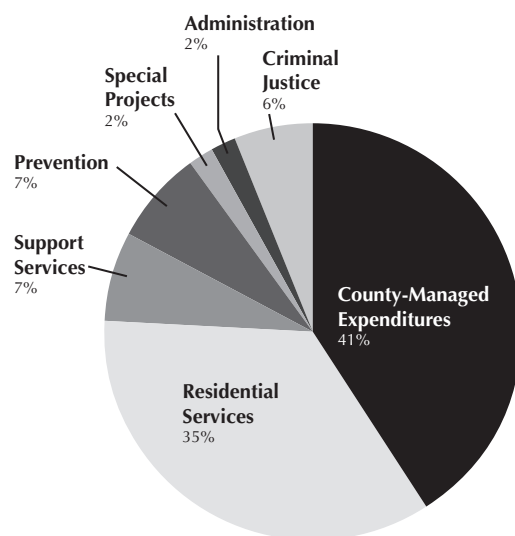


DASA's projected 2005-2007 Biennium Budget of \$303.9 million represents a 1.8% of that of the Department of Social and Health Services.



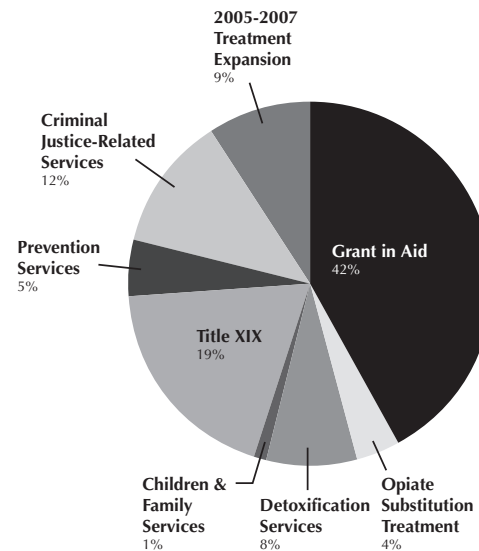


Only 2% of the Division of Alcohol and Substance Abuse's 2005-2007 Biennium Budget Will Be Spent on Administration.



Total DASA 2005-2007 Biennium Budget	\$303.9 million	
County-Managed Services	\$123.9 million	41%
Residential Services	\$106.4 million	35%
Support Services	\$20.6 million	7%
Prevention Services	\$20.6 million	7%
Criminal Justice-Related Services	\$18.7 million	6%
Special Projects	\$7.8 million	2%
Administration	\$5.9 million	2%

Half of the Division of Alcohol and Substance Abuse's 2005-2007 Biennium Budget is for County-Managed Services.



Total County-Managed Substance Abuse Services 2005-2007 Biennium Budget	\$150.8 million	
Grant in Aid	\$63.6 million	42%
Opiate Substitution Treatment	\$5.3 million	4%
Detoxification Services	\$11.3 million	8%
Children & Family Services	\$1.0 million	1%
Title XIX	\$28.7million	19%
Prevention Services	\$8.2 million	5%
Criminal Justice-Related Services	\$18.7 million	12%
2005-2007 Treatment Expansion	\$14.0 million	9%

DASA passes half of its biennial budget through to counties to provide alcohol- and drug-related prevention, intervention, and treatment services. The largest portion of these funds – Grant in Aid – can be used flexibly to meet areas of greatest need in each county.



Results of the 2005 Legislative Session

The 2005 Legislative Session represented a banner year for the Division of Alcohol and Substance Abuse (DASA). Both the Legislature and Governor expressed their confidence that the provision of quality substance abuse prevention, intervention, and treatment services results in improved public health and safety, reduced medical and psychiatric costs, less crime and lower criminal justice costs, and, among youth, better school performance and less delinquency. Significant legislation was enacted and budget expansion packages adopted with goals of closing the treatment gap, dealing more effectively with individuals in crisis, restricting access to drugs that are precursors in the manufacture of methamphetamine, and supporting the long-term success of families with children.

ESHB 1031 grants authority and funding to the Department of Social and Health Services (DSHS) to manage a Problem and Pathological Gambling Program. The program covers the prevention as well as treatment of problem and pathological gambling; the training of professionals in identifying and treating problem gambling; and the treatment of family members of problem and pathological gamblers.

HB 1872 provides that a person who is restricted to the use of a vehicle with an ignition interlock device is guilty of a gross misdemeanor if attempting to circumvent the device by tampering with it.

E2SHB 2015 revises the Drug Offender Sentencing Alternative (DOSA). While the existing DOSA sentence stays intact (an offender is sentenced to one-half the midpoint of the standard range, receives substance abuse treatment while in prison and then serves a term of community custody equal to the other half of the midpoint of the standard range, or longer based on provisions of the Offender Accountability Act), a community-based alternative is established. This alternative allows an offender to be sentenced to three to six months of residential chemical dependency treatment in lieu

of incarceration, as well as receiving a term of community custody and affirmative conditions.

ESHB 2266 restricts access to precursor drugs used in the manufacture of methamphetamine. The State Board of Pharmacy is required to implement a statewide pilot project to require collection of data related to retail transactions involving ephedrine, pseudoephedrine, or phenylpropanolamine. Sheriffs are to maintain a record of such products found at methamphetamine laboratory sites.

E2SSB 5213 supports the long-term success of families of children by removing barriers to Temporary Assistance for Needy Families (TANF) and the WorkFirst programs. In particular, those convicted of drug-related felonies who have completed their sentence are now eligible for TANF benefits upon re-entry into the community.

SSB 5644 amends current statutes so that the stay on driver's license suspensions pending entry of a deferred prosecution is extended to not longer than 150 days after charges are filed, or two years after the date of arrest, whichever is shorter.

E2SSB 5763 – “The Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005”. Among its many provisions, funding is provided to provide chemical dependency treatment to 40% of Medicaid-eligible adults in SFY 2006, and 60% in SFY 2007, as well as youth under 200% of the Federal Poverty Level. Pilot programs are created to provide intensive case management to individuals in crisis in two counties, and to set up two integrated crisis response pilots, to include secure detoxification facilities. Funds are also allocated for the expansion of the Safe Moms, Safe Babies program, and for the implementation of integrated mental health and chemical dependency screening and assessment protocols for use with all mental health/chemical dependency patients.



SB 5974 directs DSHS to adopt rules to require all opiate substitution treatment programs to educate pregnant women in their programs about the benefits and risk of methadone treatment to their fetus before they are provided with these medications.

Budget

The 2005-2007 Biennium Budget includes \$67,855,000 in new funds for DASA. Included in that increase is:

- \$1,500,000 for the prevention and treatment of problem and pathological gambling
- \$8,433,000 for target vendor rate increases for residential providers
- \$32,952,000 to greatly expand treatment access for Medicaid-eligible adults in both residential and outpatient settings
- \$6,726,000 to expand treatment access for low-income youth in residential and outpatient settings

- \$6,194,000 for two integrated crisis response pilot programs – one rural, one urban – to include secure detoxification facilities
- \$488,000 for two intensive case management pilot programs
- \$3,200,000 to expand the Safe Moms, Safe Babies program
- \$460,000 to develop integrated mental health/substance abuse screening and assessment tools, and to train providers in their use

DASA looks forward to an exciting Biennium in working with its partners in implementing the new legislation and making use of expanded budget capacity in working for the health and safety of the people of Washington.

